(51) (55)

Nos. 95-1858 and 96-110

In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, *et al.*,
Petitioners,
v.
TIMOTHY E. QUILL, M.D., *et al.*,
Respondents.

STATE OF WASHINGTON, *et al.*,
Petitioners,
v.
HAROLD GLUCKSBERG, M.D., *et al.*,
Respondents.

On Writ of Certiorari to the United States Courts of Appeals for the Second and Ninth Circuits

BRIEF AMICI CURIAE SUPPORTING RESPONDENTS OF THE AMERICAN CIVIL LIBERTIES UNION, AMERICAN CIVIL LIBERTIES UNION OF WASHINGTON, NATIONAL GRAY PANTHERS PROJECT FUND, (continued on back of cover)

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INTERESTS OF AMICI CURIAE

The interests of amici curiae are set forth in the appendix to this brief.[1]

SUMMARY OF ARGUMENT

At issue in this case is no more and no less than (1) whether a mentally competent, terminally ill person suffering intolerably has a liberty interest protected by the Fourteenth Amendment in choosing to hasten the timing of an inevitable death, (2) whether a state's interests can justify a blanket prohibition on physicians providing assistance in the exercise of such a liberty interest, if it so exists, and (3) whether a state can justifiably grant certain persons the opportunity to make the choice to hasten death while denying to other, similarly situated persons the same opportunity.

The right of a competent, terminally ill person to avoid excruciating pain and embrace a timely and dignified death bears the sanction of history and is implicit in the concept of ordered liberty. The exercise of this right is as central to personal autonomy and bodily integrity as the exercise of rights safeguarded by this Court's decisions relating to marriage, family relationships, procreation, contraception, child rearing and the refusal or termination of life-saving medical treatment. In particular, this Court's recent decisions concerning the right to refuse medical treatment and the right to abortion instruct that a mentally competent, terminally ill person has a protected liberty interest in choosing to end intolerable suffering by hastening his or her own death.

A state's categorical ban on physician assistance to suicide — as applied to competent, terminally ill patients who wish to avoid unendurable pain and hasten inevitable death — substantially interferes with this protected liberty interest and cannot be sustained. Though a state has significant interests in ensuring that the right at issue here is not abused or misused, an absolute ban on physician assistance unduly burdens the proper exercise of the right of the terminally ill to seek freedom from pain through death, especially given the less restrictive alternatives that are

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[1] Letters of consent to the filing of this brief have been lodged with the Clerk of the Court pursuant to Rule 37.3.

available to a state and that would in fact greater serve its claimed interests.

Indeed, states typically and successfully employ less restrictive alternatives than blanket prohibitions for terminally ill patients depending on life-sustaining treatment who wish to hasten death. States have recognized the right of this class of terminally ill patients to escape pain and hasten death through the termination or refusal of such life support and accompanying administration of large and lethal doses of pain-suppressing medication. Accordingly, a state denies equal protection of its laws when it provides that one class of persons may exercise this right while others who are similarly situated for all relevant purposes are wholly denied the opportunity to exercise the same right for the same reason.

ARGUMENT

I.

THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT PROTECTS THE PERSONAL CHOICE OF A MENTALLY COMPETENT, TERMINALLY ILL INDIVIDUAL TO END UNENDURABLE SUFFERING AND HASTEN INEVITABLE DEATH

The Due Process Clause of the Fourteenth Amendment declares that no State shall "deprive any person of life, liberty, or property, without due process of law." U.S. Const. Amend. XIV. The Due Process Clause has long been held to contain a substantive component forbidding certain government actions regardless of procedural fairness. See *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833, 846 (1992); *Daniels* v. *Williams*, 474 U.S. 327, 331 (1986).

The content of substantive due process — *i.e.*, the constitutionally protected interests comprehended within the term "liberty" — cannot be determined by easy reference to any rule, text or historical period. "Neither the Bill of Rights nor the specific practices of States at the time of the adoption of the Fourteenth Amendment marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects." *Casey*, 505 U.S. at 848. In the words of Justice Harlan,

> the full scope of the liberty guaranteed by the Due Process Clause cannot be found in or limited by the precise terms of the specific guarantees elsewhere provided in the Constitution.... It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints.

Poe v. *Ollman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting). Accordingly, in determining the reach of the "least specific and most comprehensive protection" that is the Fourteenth Amendment's guarantee of liberty, courts must employ considered reason and remain "duly mindful of reconciling the needs both of continuity and of change in a progressive society." *Rochin* v. *California*, 342 U.S. 165, 170, 172 (1952); see also *Casey*, 505 U.S. at 847-49 (courts must employ "reasoned judgment" to determine the scope of that "realm of personal liberty which the government may not enter").

Although the boundaries of substantive due process "are not susceptible of expression as a simple rule," *Casey*, 505 U.S. at 849, this Court has articulated two basic lines of inquiry for deciding whether a particular right falls within the liberty provision of the Due Process Clause. First, the Court has looked to whether the asserted right is "deeply rooted in this Nation's history and tradition." *Moore* v. *City of East Cleveland*, 431 U.S. 494, 503 (1977). Second, the Court has consulted the present conscience of the people to determine whether the asserted right is "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [it] were sacrificed." *Palko* v. *Connecticut*, 302 U.S. 319, 325-26 (1937).

In this case, either line of inquiry leads to the conclusion that a mentally competent, terminally ill person's decision to escape unendurable suffering by choosing to die is entitled to recognition as a constitutionally protected liberty interest. That is, the right of the terminally ill to find relief from excruciating pain by hastening death bears the sanction of history. It is also entirely consistent with other rights of fundamental personal autonomy that this Court has found "implicit in the concept of ordered liberty" and thus embraced by the Fourteenth Amendment's Due Process Clause.

A. The Right of a Mentally Competent, Terminally Ill Person to Choose an End to Suffering by Hastening an Inevitable Death Is Deeply Rooted in this Nation's History and Tradition.

Petitioners and their supporting amici contend that history and tradition support their position, but in doing so they improperly define the practice at issue here. Although history's view of suicide generally is subject to debate, this case presents only the narrow question of whether a mentally competent, terminally ill person has a right to seek an end to intolerable suffering by hastening an inevitable death.[2] Framed in these terms, the historical analysis appears very different. In fact, there is a strong historical tradition accepting, and often honoring, terminally ill persons who choose a timely and dignified death in the face of unrelenting and unendurable suffering.

This tradition traces back at least as far as the Greek and Roman philosophers, who accepted suicide where necessary to achieve a dignified death and to escape from a terminal and incapacitating disease.[3] For example, Plato's *Republic* sanctioned a choice to die under such circumstances: "If any man labour of an

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[2] The complaint in the case from Washington asserted the issue in terms of whether the "Fourteenth Amendment protects the rights of terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering." Pet. App. A17 n.7. The first paragraph of the complaint describing the nature of the action brought in New York asserted the issue in the same terms.

As the Ninth Circuit noted, following the approach of this Court's abortion decisions, the liberty interest at stake is not the right to *assistance* with suicide but, rather, the right of the terminally ill to hasten their death. If such a right exists, then the inquiry is whether a complete ban on assistance in exercising this liberty interest constitutes an undue burden. See *Compassion In Dying* v. *Washington*, 79 F.3d 790, 801-02 (9th Cir. 1996).

[3] This Court has considered the moral tradition of the Greeks in assessing other liberty interests. See *Roe* v. *Wade*, 410 U.S. 113, 130-32 (1973).

incurable disease, he may dispatch himself, if it be to his good."[4] Similarly, the Stoics of Rome, who believed that freedom must be based on the dictates of the deliberative will rather than passion or compulsion, embraced suicide as an appropriate response to a terminal illness whose overpowering physical assaults and demands would otherwise superimpose itself on the will and usurp the freedom of the sufferer.[5]

Significantly, neither the Old nor the New Testament prohibits suicide.[6] The notion of suicide as a crime was not introduced until late in Christian doctrine, and then only as a response to the temptation that martyrdom held for the early Christians.[7] Moreover,

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[4] *The Republic of Plato* Book III, 406a-409 (Alan Bloom ed. 1968). Aristotle, too, endorsed this possibility in his *Politics*. See *Aristotle's Politics* III, vi, 1278b15-30

[5] See Patricia A. Unz, Note, *Euthanasia: A Constitutionally Protected Peaceful Death*, 37 N.Y.L. Sch. L. Rev. 439, 441-42 (1992). Writing in this tradition, Seneca, the great Roman orator, stated:

> I will not relinquish old age if it leaves my better part intact. But if it begins to shake my mind, if it destroys its faculties one by one, if it leaves me not life but breath, I will depart from the putrid or tottering edifice. I will not escape by death from disease so long as it may be healed, and leaves my mind unimpaired. I will not raise my hand against myself on account of pain, for so to die is to be conquered. But I know if I must suffer without hope of relief, I will depart, not through fear of the pain itself, but because it prevents all for which I would live.

Quoted in Sherman B. Nuland, *How We Die* 151 (1993).

[6] None of the four suicides recorded in the Old Testament — Samson, Saul, Abimelech and Achitophel — is criticized. See Alfred Alvarez, "The Background" 12, *in* M. Babst Battin & David J. Mayo, *Suicide: The Philosophical Issues* (1980). The New Testament (Matthew) records the suicide of Judas Iscariot perfunctorily, "instead of being added to his crimes, it seems a measure of his repentance." *Id.* "In the first years of the Church, suicide was such a neutral subject that even the death of Jesus was regarded by Tertullian, one of the most fiery of the early Fathers, as a kind of suicide." *Id.*

[7] The Christian church taught that the world was a vale of tears, sin and temptation, from which death would release the faithful into eternal glory. Martyrdom afforded certain redemption, and the names of early martyrs were celebrated and their relics worshiped. The temptation to martyrdom culminated in the frenzy of the Donatists who, in the fourth and fifth centuries, actively pursued death. In response, St. Augustine argued in his writings that suicide was a sin.

despite the Church's general prohibition on suicide, certain prominent adherents recognized the appropriateness of choosing death as a means to end intolerable suffering for the terminally ill. Sir Thomas More, who was later canonized by the Roman Catholic Church, strongly supported the right of those with incurable diseases to commit suicide, and in *Utopia* he depicted the ideal treatment of the terminally ill, "full of continual pain and anguish," as allowing the patient to "despatch himself out of that painful life, as out of a prison."[8]

The origin of suicide as an English common law offense was also ecclesiastical; thus, the initial penalty was merely the denial of a Christian burial.[9] During feudal times, the penalty was expanded to include the forfeiture of goods to the suicide's liege lord; later, the Crown declared suicide a felony, primarily because a felon's goods were then forfeited directly to the King.[10] The common law, however, has never treated all suicides alike. Of greatest significance here, it was more lenient from the outset with those who killed themselves due to an inability to endure the suffering of disease.[11]

The crime of suicide, along with the rest of English common law, migrated to the American colonies, but it never took root even in its more limited form. As the Ninth Circuit explained: "There is no evidence that any court ever imposed a punishment for suicide or attempted suicide under common law in post-revolutionary America. By the time the Fourteenth Amendment was adopted in 1868, suicide was generally not punishable, and in only nine of the

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These arguments, coupled with the example of the Donatists, convinced the Church to legislate against suicide. See *id.* at 25-28.

[8] Quoted in O.R. Russell, *Freedom to Die* 55-56 (1975).

[9] See Maria T. CeloCruz, Note, *Aid-In-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?*, 18 Am. J.L. & Med. 369, 373 (1992).

[10] *Id.* at 373-74.

[11] See *Compassion*, 79 F.3d at 808-09 (citing 2 H. de Bracton (c. 1250) reprinted in *On the Laws and Customs of England* 423 (S. Thorne trans., 1968)).

37 states is it clear that there were statutes prohibiting assisting suicide." *Compassion In Dying* v. *Washington*, 79 F.3d 790, 809 (9th Cir. 1996).

Today, no American jurisdiction criminalizes suicide or attempted suicide. And while a small majority of states currently criminalize assistance to suicide, there is no reported American case of a physician criminally punished for helping a patient commit suicide notwithstanding the fact that assisting the terminally ill who wish to hasten their deaths has been a time-honored, though hidden, practice of compassionate physicians.[12] For well over the past half century, no person (physician or otherwise) has been meaningfully punished for aiding the terminally ill to end their suffering.[13] This reluctance to prosecute and failure to punish can only be explained by society's abiding judgment that it has no right to insist on the continued suffering of the terminally ill, and no right to punish those who honor the request of the terminally ill by assisting them in ending their agony.[14]

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[12] See *id.* at 811 & nn.56-59; see also Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 Harv. L. Rev. 2021, 2021 n.7 (1992).

[13] "[F]rom 1930 to 1985, not one state court decision on an actual prosecution for suicide assistance appears in an official state reporter." Catherine D. Shaffer, Note, *Criminal Liability for Assisted Suicide*, 86 Colum. L. Rev. 348, 358 (1986). Based on newspaper and wire service accounts, it appears that such cases either have not been prosecuted or have resulted in acquittal or sentences of probation. See *id.* In the last decade, of course, there have been several well-publicized prosecutions. All, so far, have resulted in jury acquittals. See Jeff Stryker, *A Bedside Manner for Death and Dying*, N.Y. Times, May 19, 1996, § 4, at 3.

[14] Indeed, to argue that suicide by persons suffering from terminal illness is ethically wrong, philosophers and theologians have had to resort to the concept of God's proprietary claim over his creations. John Locke argued that suicide was a crime because man does not have absolute dominion over himself; his being belongs to God and he thus has no right to destroy it. "[M]en being the workmanship of one omnipotent ... makes all servants of one sovereign master, sent into the world by his order and about his business — they are his property, whose workmanship they are, made to last during his, not another's pleasure." John Locke, *The Second Treatise of Government* 9, 17, 21 (C.B. Macpherson ed. 1980). The theologian, Dietrich Bonhoeffer, has similarly stated: "It becomes quite clear that a purely moral judgment on suicide is impossible, and indeed that suicide has nothing to fear from an atheistic ethic. The right to suicide is nullified

There is nothing new about the desire of terminally ill patients to end their suffering by hastening death. Developments in modern health care have simply brought into the open a previously private practice that society has long condoned. Until the early part of this century, patients suffering from incurable conditions overwhelmingly died at home due to the limitations of the health care system. Their deaths were frequently eased by the ministrations of alcohol and opiates.[15] Indeed, opiates (including morphine), which lead to death in excessive doses, were available without prescription until 1914. Thus, terminally ill patients had at their disposal throughout the Nation's early history the means of hastening death in a certain and gentle manner when their pain became unendurable.

With the regulation of morphine and other opiates during the last century, this gentle quitting of a life ravaged by terminal disease became dependent on the aid of compassionate physicians. The evidence shows that, despite the strictures of the criminal law, many physicians have long been willing to provide such assistance.[16] They do so in response to an undeniable reality. More recent advances in medicine, which have dramatically increased the life span of the terminally ill, have also stretched out the "death span," prolonging the agony of the end stages of terminal disease,

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only by the living God." Quoted in P. Baelz, "Suicide: Some Theological Reflections," *in* Battin & Mayo, *supra*, at 75.

However deeply held such religious views may be, they cannot (without more) be the basis for government regulation. See *Casey*, 505 U.S. at 850 (explaining that particular spiritual or moral views concerning a liberty "cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code."); *id.* at 914 (Stevens, J., concurring in part and dissenting in part) ("[I]n order to be legitimate, the State's interest must be secular; consistent with the First Amendment the State may not promote a theological or sectarian interest.").

[15] *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261, 339 n.11 (1990) (Stevens, J., dissenting).

[16] See generally Julia Pugliese, Note, *Don't Ask—Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 Hastings L.J. 1290, 1297-99 (1993); Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691, 694 (1991).

often accompanied by severe pain, physical deterioration, and unspeakable indignities.

In sum, a review of this nation's history and tradition in fact provides considerable support for recognition of a constitutionally protected liberty interest in the choice of the terminally ill to bring an end to their suffering by hastening an inevitable death.

B. The Right of a Mentally Competent, Terminally Ill Person to Choose an End to Suffering by Hastening an Inevitable Death Is Implicit in the Concept of Ordered Liberty.

The right of the terminally ill to hasten their death and escape intolerable pain is not only grounded in history, it is also implicit in the very concept of ordered liberty, as this Court has understood and applied that notion in past decisions. In particular, the combined force of *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833 (1992), and *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), leads to the conclusion that the right of the terminally ill to quit a life burdened by intractable pain in a gentle and dignified manner is at the core of the liberty interests protected by the Constitution.

Cruzan and *Casey* do not stand alone, however. They represent only the latest examples of an enduring principle that has found expression in numerous cases over the years. This Court has repeatedly protected from state intrusion a set of decisions that go to the very essence of what it means to be an individual in command of a personal history and life course — decisions relating to marriage, family relationships, conception, procreation, child rearing, education, and the refusal or termination of life-saving medical treatment. See *Casey*, 505 U.S. at 849 ("It is settled now...that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood, as well as bodily integrity.") (citations omitted). Review of this well-settled line of cases reveals the vital presence of three distinct, though interrelated, components of "liberty," each of which strongly supports a finding of constitutional protection for the right of the terminally ill to hasten inevitable death.

The first and perhaps pre-eminent component of "liberty" protects the individual's interest in personal dignity and decisional autonomy. See *Moore* v. *City of East Cleveland*, 431 U.S. 494 (1977); *Roe* v *Wade*, 410 U.S. 113 (1973); *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972); *Loving* v. *Virginia*, 388 U.S. 1 (1967); *Griswold* v. *Connecticut*, 381 U.S. 479 (1965); *Prince* v. *Massachusetts*, 321 U.S. 158 (1944). These cases develop the central notion that liberty only has meaning if an individual is able to make central decisions concerning his or her own life free from significant governmental interference. The decision in *Casey* stands as the most recent and most cogent articulation of these principles:

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

505 U.S. at 851.

It is beyond dispute that the decision to control the end of one's life when confronted with terminal illness and intolerable pain is among the most critical and personal decisions an individual can make. Indeed, given its profound significance to a person's individual, familial, moral, spiritual and religious beliefs, it is difficult to view any other life choice as striking more to the core of personal dignity and autonomy than the decision of a competent and suffering terminally ill patient concerning how and when to die. Both the majority and dissents in *Cruzan* stressed the fundamental nature of the choice at issue here. See *Cruzan*, 497 U.S. at 281 ("The choice between life and death is a deeply personal decision of obvious and overwhelming finality."); *id.* at 310-11 (Brennan, J., dissenting) ("Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence."); *id.* at 343 (Stevens, J., dissenting) ("Choices about death touch the core of liberty. Our duty, and the concomitant

freedom, to come to terms with the conditions of our own mortality are undoubtedly 'so rooted in the traditions and conscience of our people as to be ranked as fundamental.'... [N]ot much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience.") (citations omitted).

The second component of "liberty" to be found in this Court's cases involves bodily integrity. The line of cases supporting this component arose primarily in the context of medical procedures, and a person's right to direct the course of his or her own treatment. See *Washington* v. *Harper*, 494 U.S. 210 (1990); *Winston* v. *Lee*, 470 U.S. 753 (1985); *Schmerber* v. *California*, 384 U.S. 757 (1966); *Rochin* v. *California*, 342 U.S. 165 (1952); *Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905). Here the *Cruzan* decision makes the latest and most germane statement about the role of bodily integrity in liberty. The majority in *Cruzan* explained that this Court's precedents indicate that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment," 497 U.S. at 278, and Justice O'Connor in concurrence stressed that "our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination ...." 497 U.S. at 287 (O'Connor, J., concurring).

Cruzan stands for the proposition that the bodily integrity component of liberty, which encompasses the right to direct one's own medical treatment, is so fundamental that it is to be honored even when the consequence of the choice is hastening an individual's death. Accordingly, this component of liberty must extend to persons like the patient-plaintiffs who, with their lives ending and their bodies wracked with pain, sought the means to preserve their dignity and control over their bodily integrity by obtaining prescribed medication to terminate their suffering.[17]

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[17] Though the United States finds that "*Cruzan* supports the conclusion that a liberty interest is at stake in this case," Govt. Br. in *Glucksberg* at 15, it also suggests that this case does not involve *Cruzan*'s interest in "avoiding invasions of bodily integrity." *Id.* at 16. Such a view misses the reality of those who seek to exercise the right at issue here. Like the patient-plaintiffs in these cases, dying patients seeking to hasten death are typically in excruciating pain and often

The third and final component of "liberty" supporting the constitutional right of terminally ill patients to choose a peaceful death is the right to avoid intolerable suffering. As the United States highlights, see Govt. Br. in *Glucksberg* at 14, a liberty interest is surely implicated if the State itself inflicts severe pain and suffering. See *Ingraham* v. *Wright*, 430 U.S. 651, 674 (1977); see also *Hudson* v. *McMillian*, 503 U.S. 1, 9-10 (1992). A liberty interest is also implicated when the state interferes with an individual's ability to relieve his or her pain, as the United States again appropriately recognizes. See Govt. Br. in *Glucksberg* at 14-15; cf. *Estelle* v. *Gamble*, 429 U.S. 97, 104 (1976). *Casey* acknowledges that the ability to seek relief from pain is a component of the "liberty" protected under the Due Process Clause — especially when the pain at issue is itself integrally bound up with a decision which implicates the dignity and autonomy interests in directing one's own life course that are also the province of the Due Process Clause:

> The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear.... Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role.... The destiny of the woman must be shaped to a large

physically incapacitated; frequently their entire bodily existence is conscripted by the demands and relentless assaults of an incurable disease. To suggest that such persons' "bodily integrity" is unaffected if they are denied the opportunity to seek medication to bring their suffering to an end — and are thereby forced to continue an existence which they view as a torment — evinces a remarkably hollow conception of the right to bodily integrity. Of course, this Court's precedents encompass a much fuller conception of bodily integrity. As *Casey* made clear when it held that denial of access to the medical procedure of abortion touches "upon the very bodily integrity of the pregnant woman," 505 U.S. at 896, this Court has recognized an interference with a liberty interest whenever persons have particular courses of medical treatment thrust upon them or denied to them contrary to their interests or consent. See, *e.g.*, *Washington*, 494 U.S. at 229; *Jacobson*, 197 U.S. at 24-30; see also *Vitek* v. *Jones*, 445 U.S. 480, 494 (1980); *Parham* v. *J.R.*, 442 U.S. 584, 600 (1979).

> extent on her own conception of her spiritual imperatives and her place in society.

505 U.S. at 852.

The same principle applies where a state prohibition relegates competent, terminally ill individuals to continue to suffer acute pain without the option of a gentle, hastened death. Like the pregnant woman's decision, the decision of a terminally ill individual to quit life in the face of unendurable pain and certain death is too intimate, too personal, and too central to the totality and meaning of that person's life for the State to impose its own philosophical and moral imperatives upon that decision. Indeed, the personal stories of the patient-plaintiffs plainly illustrate the extent of the suffering at stake in these cases.[18] The United States properly recognizes this "significant liberty interest" in its brief, noting that "it persists even at the point at which avoiding severe pain and suffering coalesces with ending life." Govt. Br. in *Glucksberg* at 16. This view resonates fully with the decision in *Cruzan*, which

[18] Washington notes that respondents and their supporting amici placed before the Courts of Appeals numerous "anecdotes" of the terminally ill who wished to hasten their death and avoid painful, undignified and inhumane endings to their lives. The State of Washington urges that this Court not make constitutional decisions based on "anecdotes." See Washington Br. at 18. But these personal stories, though brief and obviously inadequate to portray essentially indescribable human suffering, are meant to help the Court to conjure the unimaginable pain and suffering experienced by those who might avail themselves of the right urged here. As the United States acknowledges, see Govt. Br. in *Glucksberg* at 18 & n.1, an irreducible core of terminally ill patients (including an estimated 10% of all cancer patients) cannot obtain relief through palliative treatment but are trapped in physical agony. In some cases, pain cannot be controlled even with full and appropriately timed doses of narcotics; in other cases, the toxic effects of the palliative agents may be intolerable. See Howard Brody, *Assisted Death — A Compassionate Response to Medical Failure*, 327 New Eng. J. Med. 1385 (1992). Moreover, the invocation of the capabilities of modern palliative medicine ignores the subjective nature of suffering; the diminished fortitude in the face of suffering when all hope of recovery is gone; the practical reality that pain can often only be allayed, if at all, at the cost of mental alertness; and the loss of dignity that accompanies physical deterioration. In these circumstances (the "anecdotes" that respondents and their amici place before the Court), compassion and the Constitution dictate that these terminally ill patients not be denied their wish for a hastened and gentle death.

teaches that a liberty interest persists even to the point where an individual decides to hasten his or her death through the refusal of life-sustaining treatment.[19]

These three components of "liberty," all recognized by this Court as hallmarks of "the concept of ordered liberty," forge a strong base of constitutional support protecting the right of a competent, terminally ill person to choose to end suffering by gently hastening death. To deny constitutional protection for this right would undermine concepts of liberty and autonomy previously recognized as sacrosanct. "Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny."[20] The right to define the limits of one's endurance in the face of terminal illness and to embrace a swifter, more gentle death, should be recognized as an essential component of liberty under the Due Process Clause.

II.

A BLANKET PROHIBITION AGAINST AID TO SUICIDE UNDULY BURDENS THE RIGHT OF THE TERMINALLY ILL TO MAKE RATIONAL END OF LIFE DECISIONS

If this Court determines that the right of the terminally ill to escape intolerable pain and suffering through hastening death is a liberty interest protected by the Fourteenth Amendment, there can be little doubt that the laws at issue here "operate as a substantial obstacle" to the exercise of that constitutionally protected personal liberty interest. *Casey*, 505 U.S. at 893.

Amici acknowledge that the states have a significant interest in the preservation of life that permits them to regulate, even quite extensively, the exercise of the right of the terminally ill to choose

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[19] In *Cruzan*, this Court noted that the "logic of [prior] cases" would extend the liberty interest in refusing medical treatment to refusing "the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life." 497 U.S. at 279.

[20] Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* 217 (1993).

the time and manner of their death. Indeed, such regulation is undoubtedly appropriate to ensure that the right at issue here is not misused. This case, however, does not involve regulation, but prohibition. And, in this context, it is undeniable that an *absolute* ban on obtaining assistance from a physician unduly burdens the right of the terminally ill to escape pain by hastening death. Indeed, for many terminally ill patients, it precludes it entirely. Furthermore, there are less restrictive alternatives available that would in fact better serve the interests claimed by the states in this case.[21]

A. A Blanket Ban on Assistance to Suicide Is a Substantial Obstacle to the Right of the Terminally Ill to End Their Suffering.

A state's blanket prohibition against aid in dying unduly burdens the right of terminally ill individuals to end their suffering and hasten their death, preventing significant numbers of terminally ill from achieving the release from suffering that they desire and relegating still others to unacceptable options. Along with improving and extending life, the advances of modern medicine have transformed radically the social circumstances of death. Whereas only a generation ago the vast majority of persons died at home, now approximately 80% of individuals die in hospitals and long-term care institutions.[22] It is, as a practical matter, impossible for

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[21] This Court has not always employed a single test when weighing the strength of the state's asserted justification for abridging a fundamental liberty interest. In *Casey*, the Court adopted an "undue burden" test that focussed on whether the challenged regulation placed a "substantial obstacle" in the path of a woman seeking a pre-viability abortion. In other contexts, this Court has emphasized the need for narrow tailoring. See, *e.g.*, *City of East Cleveland*, 431 U.S. at 499. Under either formulation, a total ban on physician-assisted suicide cannot be upheld. As explained below, it clearly represents a "substantial obstacle" to terminally ill individuals who wish to end their suffering and it is not narrowly tailored to achieve the state's asserted interests.

[22] See *Cruzan*, 497 U.S. at 302 (Brennan, J., dissenting); *id.* at 339-40 (Stevens, J., dissenting) ("People are less likely to die at home, and more likely to die in relatively public places, such as hospitals or nursing homes. Ultimate questions that might once have been dealt with in intimacy by a family and its physician have now become the concern of institutions.").

the terminally ill who are institutionalized to obtain release from suffering unassisted; without aid, they are unable to obtain the means for a swifter death. Moreover, a state's blanket prohibition against aid in dying presents an absolute obstacle to those who do not wish to quit their lives until their terminal illnesses progress to the point at which they lack the very strength to accomplish suicide unassisted. One consequence is particularly intolerable. Faced with increasing weakness and loss of autonomy in the final stages of an illness, terminally ill patients who have chosen to avoid lengthy and excruciating deaths are frequently forced to end their lives prematurely for fear that further loss of strength or intense medical supervision effectively will deprive them of their choice.

Furthermore, such terminally ill patients often are driven to end their lives by violent means and entirely alone. Ironically, such violent means are often legally accessible, whereas the medical means that might allow the patient to quit life gently are now inaccessible in the absence of a physician willing to transgress the law. The fear of implicating one's friends or family in crime, moreover, often induces the terminally ill to carry out their resolve secretly and alone. The trauma is then magnified for friends and family who must deal not only with the death, but the gruesome means employed and the fact that their loved one was forced to meet death unsupported and alone.[23]

Other terminally ill individuals determined to end their suffering frequently turn for help to friends or family members, who must then choose between love and compassion or the dictates of the law.[24] Another cruelty caused by the ban on assistance is that

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[23] The ban on physician assistance may not only cause terminally ill individuals to commit suicide prematurely or preclude a gentle death or one in the company of friends and family, but it also may frustrate the very desire for certain death when self-inflicted attempts fail, thereby causing additional and gratuitous suffering to the tormented patient. See Quill, *supra* note 16, at 117-20.

[24] See, *e.g.*, K. Frederickson, *Torn Mother: I Helped Her Pass On*, Oregon Bulletin, May 16, 1994, at A1 (giving account of mother's explanation, after expiration of statute of limitations, of how she finally acceded to daughter's plea to assist her suicide after months of watching her wasting from bone cancer in too much pain to endure even her mother's touch).

non-physician assisted suicides are amateurish affairs, always clandestine and often bungled. One Canadian study of "back-alley euthanasia" among the Vancouver AIDS population found that one-half of assisted suicides were botched, perversely increasing — rather than alleviating — suffering.[25]

B. The States' Asserted Interests Do Not Justify an Absolute Ban on Physician Aid in Dying for the Terminally Ill.

In opposition to this right, Washington and New York invoke interests in preserving human life, precluding undue influence or mistake, safeguarding the integrity of the medical profession and a concern over the "slippery-slope" — *i.e.*, that line-drawing in this area will prove impossible. These interests and concerns, however legitimate, do not justify an absolute ban on physician aid in dying for terminally ill persons and should not outweigh the recognized right of a competent, terminally ill individual to end his or her suffering.

1. Interest in Preserving Each Citizen's Life

First, as this Court has determined, a state's interest in the preservation of every citizen's life, such as that asserted by New York and Washington here, abstracted from the value that a particular person may place on the continuation of that life, cannot outweigh a terminally ill individual's choice to end suffering and quit a life burdened by intractable pain and irreversible disintegration. See *Casey*, 505 U.S. at 857 ("[A] State's interest in the

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[25] See Clyde H. Farnsworth, *Vancouver AIDS Suicides Botched*, N.Y. Times, June 14, 1994, at C12. For example,

> In five cases, victims were unsuccessfully suffocated. In one case, the people who assisted in the suicide resorted to slitting the victim's wrists with a razor blade and in another case to shooting him. Two were injected with pure heroin. Many of the acts of euthanasia took several hours or longer to be completed. In one case it took four days.

Id.; see also Gina Kolata, *AIDS Patients Seek Solace in Suicide But Many Risk Added Pain in Failure*, N.Y. Times, June 14, 1994, at C1 (reporting on man who, in trying to bring on a gentle death by smothering his lover with pillow, asphyxiated him only enough to destroy most of his brain function).

protection of life falls short of justifying any plenary override of individual liberty claims.").[26]

Second, the pitiless process by which many terminally ill persons die — the unremitting pain, the erosion of privacy and dignity, the loss of control over basic bodily functions — leads some to conclude that the burden of their corporeal existence degrades the very humanity it was meant to serve. In choosing to end their suffering, the terminally ill do not repudiate an interest in life but seek to affirm a meaningful life with a dignified death.[27]

In these circumstances, a state may not insist that the terminally ill endure the unendurable in order to promote the state's abstract interest in the preservation of life. To do so is to appropriate an individual's existence, and to prolong cruel and unusual torment, for the purpose of proselytizing the state's preferred philosophical view of life. This a state may not constitutionally do.[28]

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[26] In *Cruzan*, the majority stated :

> we think a State may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.

497 U.S. at 282. Indeed, a state has no other choice. More specifically, a state cannot make determinations about the worth or quality of an individual's life and then rely on that determination as a basis for making life or death decisions. For the terminally ill, the meaning of life and the impact of physical and psychological agony represent the most personal of judgments that the state may not usurp.

[27] As Justice Stevens noted, an interest in life "includes an interest in how [one] will be thought of after ... death by those whose opinions mattered" during life. "How [one] dies will affect how that life is remembered." *Cruzan*, 497 U.S. at 344 (Stevens, J., dissenting). Those enduring a life racked with pain and utter helplessness may reasonably reject the prospect of a long vigil where family and friends loyally and lovingly witness their disintegration. The terminally ill reasonably may assert an interest in being remembered for how they lived rather than the excruciating, relentless and lengthy process by which they died.

[28] A state may not even use a person's car as a moving billboard to proselytize its views on life's meaning by insisting that the state's motto appear on citizens' license plates. See *Wooley* v. *Maynard*, 430 U.S. 705 (1977). In the abortion context, a state may not insist that a woman carry a not-yet-viable life to term to affirm the state's view of women's role or its philosophic view of when life

2. Preventing Undue Influence or Mistake

Washington and New York also rely on their interest in protecting vulnerable citizens. They argue that the right at issue, if recognized, would be subject to abuse and mistake — that requests for aid in dying would be mistakenly granted to those not terminally ill (because incorrectly diagnosed) or to those whose request was not truly voluntary (due to undiagnosed depression, lack of capacity, inadequately treated pain, or undue influence from family or physician).

These concerns, however, are not unique to the present situation. The risk of abuse or mistake exists in many medical contexts, including the end-of-life decisions already condoned by the State. These risks are routinely and appropriately dealt with through regulation. For example, only an informed competent adult may consent to an order not to resuscitate. See, *e.g.*, N.Y. Pub. Health Law §§ 2960 *et seq.* (McKinney 1993). Similarly, only a competent principal may appoint a health care agent (who may be a family member) who has the power to decide not to resuscitate or to terminate life support for the principal in the event of incapacity. See, *e.g.*, N.Y. Pub. Health Law § 2981 (McKinney 1993). Indeed, under applicable state statutes, a finding of competence is a necessary precondition to the execution of health care directives.[29]

If the law permits life-ending actions to be taken on the basis of competence in other medical contexts, there is no reason to claim that such a determination is impossible in this setting. Moreover, the recognition of the right to physician aid-in-dying would better address some of the state's concerns here. Whereas the current legal regime may lead the terminally ill to hide their wish for suicide from their doctor for fear that needed pain medication may be withheld, recognition of the right to physician assistance in hastening death would encourage frank discussion between the terminally ill considering suicide and their treating

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begins. See *Casey*, 505 U.S. at 851. Equally, a state may not promote its view of the sanctity of life by insisting that a terminally ill individual bear unrelieved suffering rather than hasten death.

[29] See generally *Compassion*, 79 F.3d at 818 (citing numerous statutes).

physician. Such discussions necessarily would raise the issue of the patient's mental state and the pain being experienced, and lead to the provision of treatment for depression, where warranted, or for pain, where all available methods have not been tried. Furthermore, where family or friends have improperly planted the thought of suicide, involvement of an objective physician would be salutary.

With respect to the concern over mistaken diagnosis (as with the previous concerns), safeguards short of an absolute ban can be crafted to minimize the likelihood of misdiagnosis to a very small order of probability.[30] Furthermore, the risk is equally present in other end-of-life decisions already condoned by the state such as the withdrawal or refusal of life-support by the terminally ill.[31]

Furthermore, the state's concerns regarding mistake in the exercise of the right ignore the consequences of a prophylactic outright ban on the terminally ill who are unquestionably competent and unquestionably in the end-stage of terminal disease. These terminally ill would be left acutely to suffer — having been foreclosed, as the United States acknowledges, from the "one

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[30] Model regulations have provided that a patient seeking physician assistance in hastening death receive confirmation by at least two physicians (or an entire committee of physicians) that they are in the terminal phase of their illness before such a request will be honored. See *infra* p. 22 & n.34.

[31] The United States argues that an incorrect diagnosis in the case of the withdrawal of life support does not, as it would here, result in death. See Govt. Br. in *Quill* at 14. In support, the United States points to Karen Ann Quinlan, who lived for years after her life support was disconnected. *Id.* But the Government's argument conflates two possibilities of misdiagnosis at stake in a terminally ill patient's decision to withdraw life-support and hasten death: dependence on life-support (not at issue in this case) and the terminal phase of an irreversible disease (which is at issue in this case). Withdrawing life-support does not lead to death where there has been a misdiagnosis of dependence on life support. On the other hand, where the misdiagnosis involves the reversibility of the disease (*i.e.*, whether it is terminal) — the only diagnosis at issue here — a misdiagnosis leading to withdrawal of life support will lead to a death. In such cases, a person whose condition might have improved if retained on life support, is removed from life support and allowed to die. Despite such risks (which can be and are minimized through requirements of diagnostic confirmation), the right to hasten death through directing the discontinuation of life support has been vouchsafed to the terminally ill.

humane and certain route of escape from pain and suffering." Govt. Br. in *Quill* at 15. These individuals, whose lives have already been so horribly compromised, cannot be forced to such a sacrifice.

Moreover, the current *unregulated* practice of assisted suicide by the terminally ill is clearly more subject to the abuse and mistake that concern petitioners and their amici. Existing back-alley methods provide no safeguards at all and thus no assurance that diagnosis will be accurate, that depression will be identified, and that undue influence has not been exercised. Yet, if the right claimed here is not recognized, certain terminally ill patients who are incapable of enduring further suffering will resort to self-help or the back-alley methods currently available with all of their significant risks.

Accordingly, amici urge recognition of the right claimed by respondents. Amici also support the use of legislative safeguards to ensure that all requests of the terminally ill for aid in dying are the product of thoughtful and informed self-determination.[32] Petitioners have offered no persuasive justification to support the need for a total prohibition.[33]

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[32] The recommendation of the New York State Task Force, relied on heavily by petitioners and their amici, is instructive in this context. In its 1994 report, *When Death Is Sought; Assisted Suicide and Euthanasia in the Medical Context*, the New York State Task Force on Life and the Law unanimously recommended that New York's statutory ban on assisting suicide be retained due to the risk of abuse and mistake if physician-assisted suicide for the terminally ill was allowed. In support of its recommendation, the New York State Task Force, like New York and Washington herein, focused on requests that were or might be made due to untreated pain or depression or undue influence. But when confronted with the specific issue raised by these cases — voluntary requests from the competent and suffering terminally ill — some Task Force members endorsed assisted suicide as a means of showing respect for the autonomy, and compassion for the suffering, of these patients. They preferred, however, that such patients obtain medical help clandestinely from courageous doctors willing to violate the law. See *id.* at 141. Thus, in the circumstances directly and solely at issue here, some members of the Task Force urged that the New York laws be disobeyed.

[33] The briefs of petitioners and their supporting amici rely on anecdotes (and selective studies — which are not uncontradicted — about experiences in another nation) to argue that regulation could not effectively safeguard the right claimed here. Notably, these anecdotes do not involve the exercise of the right to the

Indeed, several model statutes for physician assistance to the terminally ill already exist that incorporate procedural safeguards to screen out inappropriate cases, including requirements of: witnesses to ensure voluntariness (neither related to the patient nor involved in his or her treatment); reasonable waiting periods to preclude rash decisions; confirmation by a second physician of the terminal diagnosis and that the patient has been receiving proper palliative care; psychological examination to ensure that the patient is not suffering from a momentary or treatable depression; and reporting procedures.[34]

3. Implicating Doctors in Killing and Slippery-Slope Arguments

Petitioners and their amici also contend that affirming the decisions below will lead to the erosion of society's confidence in the medical profession by implicating physicians in intentional killings. But, as the Second Circuit correctly noted, the physician assistance sought by patient-plaintiffs in this case, "the writing of a prescription to hasten death ..., involves a far less active role for the physician than is required in bringing about death through" the withdrawal of life support. *Quill* v. *Vacco*, 80 F.3d 716, 729 (2d Cir. 1996). Accordingly, the right the patient-plaintiffs wished to exercise in this case implicates doctors in intentionally killing, and risks tarnishing their image, no more than does the currently

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refusal or withdrawal of life-sustaining treatment which *has* been effectively regulated. Instead, petitioners and their amici rely largely on hypothesized scenarios and anecdotes relating to the clandestine exercise of physician aid in dying, which at present is illegal and entirely unregulated. Neither these, nor the disputed experience of another nation, provide a sufficient basis to argue against the right urged here.

[34] See Oregon's Death with Dignity Act, Or. Rev. Stat. §§ 127.800-127.995 (1995); Michigan's Model Statue Supporting Aid-in Dying, appended to the Final Report of the Michigan Commission on Death and Dying (1994); New York, Senate Bill No. 7986 (May 3, 1994) entitled "Death With Dignity," sponsored by New York State Senators Galiber, Leichter, Markowitz, Smith and Waldon; Washington Senate Bill 5596 (Jan. 27, 1995) entitled "Terminally Ill Patient Act of 1995." Of course, the constitutionality of particular restrictions is not before the Court since the two state statutes in this case are both total bans.

sanctioned practice of removing life-sustaining medical treatment. See *Compassion*, 79 F.3d at 828 ("Given the similarity between what doctors are now permitted to do and what the plaintiffs assert they should be permitted to do, we see no risk at all to the integrity of the profession."). Furthermore, since safeguarding of the right at issue here will permit and encourage candid discussions of all available options between the terminally ill and their physicians, instead of "criminaliz[ing] the provision of medical assistance to patients in need," *id.* at 827, recognizing the right of the terminally ill to obtain the relief they seek from their doctors would foster rather than erode public confidence in the medical profession.

The other argument raised by petitioners and their supporting amici is that recognition of the right to physician aid in dying urged here would somehow be uncontainable. These sorts of slippery-slope arguments can be made in opposition to any constitutional right (and have been leveled against many recently recognized rights, including the right to terminate life-sustaining treatment). Recognition of any right creates the possibility of its abuse; but petitioners do not raise any cogent concerns that could not be addressed in ways that still allow the right to be exercised.

Finally, Petitioners point to the difficulty in defining the category of the "terminally ill." In fact, this term has been used (and defined) in "living will" statutes in effect in 40 states. See *Compassion*, 79 F.3d at 818 & nn.77-78 (listing state statutes). While the term is not free from difficulty, it has proved workable and is not problematically vague.[35]

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[35] Petitioners point further to the difficulty in distinguishing between a physician's prescription of lethal medication to be self-administered by a terminally ill patient and a physician's administration of that medication where the terminally ill individual is unable to do so. Amici acknowledge that some terminally ill patients who voluntarily request a hastened and gentle death may, due to the devastating progress of their disease, be unable physically to ingest medication without assistance. The question whether the physician's administration of the medication could be constitutionally prohibited in such a case is not presently before the Court. Amici, however, agree with the Ninth Circuit that the crucial question is whether the request is thoughtful and voluntary and, if so, the terminally ill patient who is physically unable to administer the medication that would release him from his agonies cannot, consistent with the Constitution, be

III.

BECAUSE TERMINALLY ILL PATIENTS ON LIFE SUPPORT HAVE THE RIGHT TO MEDICAL ASSISTANCE IN HASTENING DEATH, DENYING TERMINALLY ILL PATIENTS NOT ON LIFE SUPPORT MEDICAL ASSISTANCE IN HASTENING DEATH VIOLATES THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT

The arguments supporting the right urged here are further buttressed by the fact that New York, Washington and most other states have recognized the right of a competent, terminally ill patient to choose to end a dehumanizing process of dying by hastening inevitable death. Indeed, they have recognized the right to physician assistance in implementing this choice. Most states, however, have explicitly extended this right only to a limited category of terminally ill patients: those dependent on life-support, including life-sustaining hydration and nutrition, who are permitted to end their suffering by directing the termination of such treatment even where the express purpose of such action is to hasten death. Physicians who comply with these directives are immune from criminal liability. But other terminally ill patients, also facing imminent death but not undergoing such treatments, are not granted the right to truncate a dehumanizing and agonizing dying process and to embrace a swifter death through medical assistance.

The Equal Protection Clause mandates that "all persons similarly circumstanced shall be treated alike." *Royster Guano Co.* v. *Virginia*, 252 U.S. 412, 415 (1920). The Second Circuit recognized that, with respect to the decision to end intolerable suffering by hastening an inevitable death, all terminally ill persons are

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prevented from obtaining the necessary aid. See *Compassion*, 79 F.3d at 831-32. The fact that the right urged here may one day properly be extended to include such a case is no cause for alarm. It bears no relation to the entirely speculative, nightmare scenarios pained by certain amici supporting petitioners: that the right urged here — a right of the individual against the state for release from the unendurable ravages of terminal disease — somehow will metamorphosize into the ability of society to act against the individual and do away with those whose lives are no longer valued. Such dark fantasies should be disregarded.

similarly situated, whether or not on life support. But, by denying only those not on life support access to a medical means to achieve their desired end, "New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths." *Quill* v. *Vacco*, 80 F.3d 716, 727 (2d Cir. 1996). Accordingly, New York's laws (and their Washington equivalents) which prohibit only some terminally ill from obtaining an escape from their pain "are violative of the Equal Protection Clause." *Id.*

Petitioners argue that there is a constitutionally significant distinction between the withdrawal of medical treatment (even life-sustaining medical treatment) and the release from suffering sought by the respondents in this case. In fact, as the United States essentially acknowledges, see Govt. Br. in *Quill* at 10, 13, and as the Second Circuit found, see *Quill*, 80 F.3d at 729-30, there is no material distinction between the patient's choice in either case or between the physician's involvement in accomplishing that choice.

In both cases the patient is making the decision to curtail weeks or months of suffering in the face of further devastation and certain death. Terminally ill patients who request the discontinuance of life-sustaining treatment, like the terminally ill patient-plaintiffs who by this action sought to hasten death by consuming drugs prescribed for this purpose, have made a conscious decision to die and seek medical assistance to accomplish their desire.[36] The medical assistance required to implement this choice is far greater (both in terms of quantity of activity and causal nexus to death) than the prescription of medication to be self-administered by the terminally ill. In the case of the withdrawal of life support, the physician must remove the medical machinery sustaining life, monitor the resultant accelerated dying process and administer morphine or barbiturates to ease the pain that would otherwise

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[36] See *Quill*, 80 F.3d at 729 (citing *Cruzan*, 497 U.S. at 296-97 (Scalia, J., concurring)).

attend such a death. These medications typically must be administered in doses that in fact precipitate an even earlier death.[37]

Thus the Talmudic distinction petitioners press between the allegedly "natural" death accomplished by withdrawing life-sustaining treatment and the allegedly "unnatural" deaths sought here, is not sustainable. In both cases the motive force is the patient's intention to hasten impending and certain death and in both cases the physician provides the medical assistance to ensure that the patient's desire can be accomplished in a certain, gentle and medically supervised manner. As the Second Circuit rightly concluded in *Quill*, the withdrawal of life-sustaining treatment by the physician is not "passive" assistance to that desire nor does it allow for a "natural" death. See 80 F.3d at 729.

Petitioners' specious distinction between, and undue emphasis upon, natural and unnatural deaths has warped treatment decisions made by compassionate doctors wishing to respond to requests from terminally ill patients who are not on respirators or receiving artificial nutrition and hydration but who, nonetheless, have reached the limit of their endurance. In such cases, physicians sometimes have aided these patients by contriving a death that mimics those regarded by petitioners as "natural." This practice, sometimes referred to as terminal sedation, involves medicating the patient into a sleep-like state until the patient dies of starvation or dehydration, days or perhaps weeks later. See AMA Br. in *Glucksberg* at 10; Resp. Br. in *Quill* at section III.B.

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[37] The Second Circuit's discussion of this point bears repeating:

> [T]he writing of a prescription to hasten death, after consultation with a patient, involves a far less active role for the physician than is required in bringing about death through asphyxiation, starvation and/or dehydration. Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide.

Quill, 80 F.3d at 729.

Indeed, as part of palliative care for the terminally ill, doctors routinely have supplied the causal agent of patients' deaths under the doctrine of "double effect." Where the terminally ill suffer from intractable pain in the final stages of disease, doctors sometimes will choose to administer an intravenous morphine drip that eases suffering by inducing a sleep-like state and also hastens death by suppressing respiration; as with terminal sedation, death may be precipitated in a matter of days. Medical ethicists and the Catholic Church justify action such as terminal sedation and morphine drips on the ground of the "double effect," reasoning that the physician's operative intent is to relieve pain, while death is regarded as a foreseen but unintended consequence.

But the patients at issue in these cases also seek a release from suffering, and also believe that such relief can only be accomplished by their deaths. There is no constitutionally cognizable reason that the prescription of medication to eliminate suffering and achieve a peaceful death can only be legally permissible where death is accomplished gradually (by starvation, dehydration or asphyxiation) while the patient is put into a twilight zone that can last days or weeks. This option, where one is subject to the unknown sensory experiences and state of consciousness that might attend such a drug induced coma, while one's loved ones stand vigil for days or weeks, may appear a monstrous and horrifying prospect to the terminally ill who wish for a certain and gentle death.

Moreover, the practice of terminal sedation and intravenous morphine drip places the decision in the hands of doctors rather than patients.[38] Amici urge that the right pressed here — which is

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[38] Where a patient requests aid in dying quickly, the patient endangers the delicate excuse of the "double effect" and a doctor who otherwise might have employed a morphine drip may demur, afraid of running afoul of the criminal law. See Thomas A. Preston, *Killing Pain, Ending Life*, N.Y. Times, Nov. 1, 1994, at A27.

also meant to relieve suffering by hastening inevitable death — better serves the needs and autonomy interests of terminally ill patients.

The distinction urged by petitioners between the competent terminally ill who wish to die and those who wish to terminate life-sustaining treatment (or who are willing to undergo terminal sedation) certainly cannot survive the heightened scrutiny required when fundamental rights are at stake and, as the Second Circuit found, its very rationality is difficult to ascertain.[39] In short, because a complete ban on the prescription of medication to competent terminally ill patients who wish to hasten death does not serve the state's expressed interest as well as would appropriately drawn regulations, it is violative of the Equal Protection Clause.

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[39] Interestingly, the United States suggests that this Court need not be especially vigilant in reviewing the state's line drawing here because "[t]erminal illness does not single out any discrete or insular minority; it potentially affects all Americans." Govt. Br. in *Glucksberg* at 31-32. On this basis, the United States asserts that "there is every reason to believe that the state legislatures will address the competing interests in an impartial and unbiased way," and also contends that "there is no indication that the political processes are malfunctioning." *Id.* at 31 & n.3. This argument fails, of course, if a fundamental liberty interest is at stake because, in that circumstance, heightened scrutiny is required regardless of whether a discrete and insular majority is involved.

Furthermore, as a matter of practice, it is difficult to put faith in the political processes which have traditionally not acted to safeguard the right of the terminally ill to escape pain through a gentle, hastened death while prosecutors, courts and juries have never meaningfully punished anyone for helping the terminally ill exercise this right. See *supra* p. 7 & nn.12-13. This disjunction between the law on the books and the law in enforcement bespeaks a malfunctioning of the political process.

CONCLUSION

For the foregoing reasons, Amici respectfully request that the judgments of the Courts of Appeals be affirmed and that the New York and Washington statutes prohibiting physician-assisted suicide be declared unconstitutional as applied to mentally competent, terminally ill perso ıs requesting such aid to escape unendurable suffering.

Respectfully submitted,

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Dated: December 10, 1996

APPENDIX

Appendix

INTERESTS OF AMICI CURIAE

The American Civil Liberties Union ("ACLU") is a nationwide, nonprofit, nonpartisan organization with nearly 300,000 members dedicated to preserving the principles of liberty and equality embodied in the Constitution. Since its founding in 1920, the ACLU has participated in numerous cases before this Court. Of particular note here, the ACLU appeared as counsel in both *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 112 S. Ct. 2790 (1992), and *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261 (1990). The ACLU of Washington is a state affiliate of the ACLU and appeared as amicus curiae before the Ninth Circuit in *Compassion In Dying* v. *Washington*.

The National Gray Panthers Project Fund is a civil liberties advocacy project concerned with social justice for the aging. As advocates for the aging, the Gray Panthers and their state affiliates of Washington and New York join in this case, as a friend of the court, to highlight the right of individuals to make choices about the quality of their lives.

The Japanese American Citizens League ("JACL") is a national civil rights organization founded in 1930, committed to strive to secure justice and equal opportunities for all Americans of Japanese ancestry as well as for all Americans, regardless of race, creed, color, national origin, religion, sex, sexual orientation, or disability. The JACL supports legislative initiatives that provide for the welfare of the broader community. The Pacific Northwest District of JACL also joins in this amicus brief as a advocate for the health care needs, as well as the death with dignity needs of its membership and of the total community, upholding the individual's right to freedom of choice on those matters that are essential to basic human dignity.

The Humanists of Washington is a freethought association dedicated to the principles of secular humanism. The group supports intellectual freedom, free inquiry, critical thinking, and civil liberties. Humanists of Washington's defense of civil liberties is unconditional; it works for the right of individuals to make personal decisions about their bodies free from unnecessary

government intrusion. Accordingly, the group defends, among other things, the right of terminally ill persons to choose the time and manner of their death.

The **Hemlock Society USA** was formed in 1980 to achieve the legalization of physician aid in dying for terminally ill, mentally competent adults. It has 25,000 members in 80 chapters and community groups throughout the country. The New York State and Washington State affiliates join the national organization in supporting the right of dying persons to work with their physicians so that the voluntary request for a hastened death may be part of the continuum of care available to the terminally ill.

The **Euthanasia Research & Guidance Organization ("ERGO!")**, a non-profit educational corporation organized under the laws of the State of Oregon, was founded in 1993 to lay the groundwork for the compassionate and just implementation of a mentally competent terminally ill adult's decision to hasten death when the law permits it in America. ERGO promotes safeguards and guidelines on legal, medical, and ethical issues so that physician aid in dying will be put into careful practice. Its goal is to educate and prepare individuals and institutions, ensuring a smooth transition when the change in law occurs. ERGO supports the respondents' position that a mentally competent terminally ill adult has the right to hasten inevitable death with the assistance of a physician.

AIDS Action Council is the Washington, D.C. representative of over 1,000 community-based organizations and the people living with HIV/AIDS they serve across the nation. As the only national organization devoted entirely to federal advocacy on behalf of people living with HIV/AIDS, AIDS Action works to ensure that effective national initiatives for prevention, care, and research are developed and implemented which are responsive to and respectful of the needs of all people living with or at risk of HIV/AIDS. In that regard, AIDS Action supports policies that empower people living with AIDS to exercise their fundamental right to make individual decisions about how they live with this disease, including their right to choose in a dignified and humane way the manner and time of their death with the assistance of their physicians.

The Northwest AIDS Foundation is the largest private, non-profit HIV/AIDS service and education organization in Washington state. The Foundation is dedicated to ensuring and maintaining the highest quality of life for persons living with HIV/AIDS, preventing the spread of HIV and advocating for all those whose lives have been affected by HIV/AIDS. Knowing the pain their clients experience as their illness becomes terminal, incapacitating, and untreatable, the Foundation supports the right of all persons with a terminal illness to decide for themselves when to end their own lives and for those individuals to seek assistance in doing so if they so wish.

The Seattle AIDS Support Groups ("S.A.S.G.") mission is to provide emotional support in a group setting (via support groups and a drop-in center) to persons living with HIV/AIDS and to their families, friends, and loved ones. The group's commitment is to create a safe and supportive environment fostering dignity, fullness of life and personal empowerment for persons with AIDS. By fostering dignity and personal empowerment, S.A.S.G. seeks to validate each individual's own choices about living and dying with this disease. The group believes that the option to hasten inevitable death should be a right for all terminally ill persons who elect to make that choice.

Local 6 of the Service Employees International Union ("Local 6") is a labor union representing 10,000 workers in Washington. As almost every improvement in the condition of working people has been accomplished by the efforts of organized labor and as the welfare of workers in Washington can best be protected and advanced by united action, the mission of Local 6 is to gather and expend its resources and to unite and empower its members for the advancement of working people. As a organization, Local 6 believes that people should exercise control over their lives and take responsibility for their decisions.

The mission of **Temple De Hirsch Sinai ("Temple")** is to serve the spiritual needs of its congregation through the observation, celebration, and study of reformed Judaism. It affirms the principles of reformed Judaism through its religious services, life

cycle ceremonies, religion school, social action, and outreach to individuals and families. The Temple promotes Jewish ideals in personal conduct, dedication, family and community life, and in its partnership with other institutions. Its interest comes under the tenets of the Old Testament, where all Jews are admonished to assist and share with the provision of food, clothing, and shelter for those less fortunate. The Temple's specific interest in this case is equal treatment of all citizens of this country.

The Older Women's League ("OWL") is a national organization working to better the lives of all midlife and older women. One of its agenda items is "Staying in Control Through All of Life." OWL works to improve policies and legal means to protect each individual's decision-making capability affecting quality of life until its ending. The Seattle/King County Chapter of OWL joins as amicus to support the right of the terminally ill to decide to end their suffering.

AMICUS CURIAE

BRIEF

(56) (58)

Nos. 96-110 and 95-1858
IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1996

State of Washington
v.
Glucksberg

Vacco
v.
Quill

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND AND NINTH CIRCUITS

Brief for the *Amici Curiae*: Gay Men's Health Crisis and Lambda Legal Defense and Education Fund: On Behalf of their Members with Terminal Illnesses; and Five Prominent Americans with Disabilities: Evan Davis, Hugh Gregory Gallagher, Barbara Swartz, Michael Stein and Susan Webb In Support of Respondents

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I. INTERESTS OF AMICI CURIAE[1]

People with disabilities do not speak with one voice on whether individuals with terminal illnesses should be permitted to end their own suffering with the assistance of their physicians and to choose a death with dignity. While some members of the disability community have been extremely vocal in opposing the right to assisted suicide, the majority of individuals with disabilities, including the *Amici* filing this brief, believe that such a right exists – that it is entirely consistent with our Constitutional tradition and the hard-fought rights secured by the disability rights movement in this country.

Amici are individuals and organizations representing people with a broad array of disabilities who share the common belief that individuals with disabilities should have autonomy over the decisions that affect their lives. They believe that the fundamental right of self-determination must apply to all significant life decisions, including what is perhaps the most intimate and personal decision of all, whether to hasten impending death if their conditions become terminal and they are suffering intolerably.

The two *Amici* organizations represent people who have AIDS, some of whom are in the terminal phase of their illnesses. The Lambda Legal Defense and Education Fund is a national non-profit public interest legal organization working for the civil rights of people with HIV and AIDS. The Gay Men's Health Crisis is the oldest and largest not for profit AIDS organization providing services to people with AIDS and their loved ones, educating the public and advocating for fair and effective AIDS policies. These organizations contend that the state should not be allowed to prohibit their members from receiving the assistance of their physicians in ending their lives when they have decided that life is no longer bearable.

[1] Amici were granted consent to file this brief.

The individual *Amici* are leaders in the disability community or prominent individuals with disabilities. Evan Davis is a partner with a major national law firm who had polio at age five. Hugh Gallagher is one of the leading historians on disability in this country. Michael Stein is the former President of the National Disability Bar Association. Barbara Swartz is a professor who has kidney disease. Susan Webb is the director of an independent living center for people with disabilities and an elected member of a national disability rights organization. All have disabilities but not terminal illnesses, and believe that they should have the right to hasten their death should they ever become terminally ill. Their personal statements are attached as an appendix to this brief.

Amici believe that the Constitution guarantees people with terminal illnesses the right to end their lives in a manner that allows them to maintain personal dignity. The attempt of Petitioners and their *amici* to use disability to justify state deprivation of this fundamental right is deeply offensive to *Amici* and the thousands of people with disabilities they represent.

A. The Disability Rights Movement

The disability rights movement is a social movement with the goal of achieving independence and autonomy for people with disabilities in all aspects of their lives. Gerben DeJong, *Independent Living: From Social Movement to Analytic Paradigm*, 60 Arch. Physical Med. Rehab. 435 (1979).[2] Judy Heumann, one of the pioneers of the movement, co-founder of the World Institute on Disability and currently the Assistant Secretary for Special Education and Rehabilitation Services at the U.S.

[2] The terms "disability rights movement" and "independent living movement" are often used interchangeably by members of the disability community. Whether they are two separate social movements or two names for basically the same movement is a matter of debate. For purposes of this brief, the broader term "disability rights movement" is used to refer to both.

Department of Education, expressed the driving spirit of the movement best in an early policy report:

> To us, independence does not mean doing things physically alone. It means being able to make independent decisions. It is a mind process not contingent upon a "normal" body.

Susan Stoddard Pflueger, *Independent Living: Emerging Issues in Rehabilitation*, foreword ii (December, 1977) (unpublished report on file with the Institute for Research Utilization).

Similarly, Edward V. Roberts, one of the founding fathers of the movement, made the following observation:

> I believe that the basic premise of the ... movement is that everyone has potential to live more independently. Our experience shows that **even the most severely and profoundly disabled individual can be independent – they may need all kinds of help – But that they can be in control of their lives.**

Id. at 1 (emphasis added).

Over time, the movement has been successful in altering the general belief in our society that people with disabilities are invariably vulnerable, exploitable, and incapable of making decisions that fundamentally affect their lives. Until recently, however, most people with disabilities accepted the predominant paternalism concerning disability and the control of their lives by other people, often to their detriment. It was only after three decades of political struggle, with the bipartisan enactment of The Americans with Disabilities Act of 1990 (the ADA)[3] that our nation developed a consensus that competent adults with disabilities can and should exercise control of their lives in the mainstream of our society.[4]

Among the rights that the movement has secured for people with disabilities are the right to live in the community, as opposed to in isolated, degrading and disempowering institutions, *Youngberg v. Romeo*, 457 U.S. 307 (1982); the right to be free of involuntary sterilization, *Relf v. Weinberger*, 372 F. Supp. 1196 (D.C.D.C. 1974), the right to raise a child, *In re Marriage of Carney*, 598 P.2d 36 (Cal. 1979); the right to have access to public streets, public transportation, schools, public services, privately owned places of public accommodation and places of employment, 42 U.S.C. §§ 12111-12181; and the right to a free and appropriate education, 20 U.S.C. § 1400 *et seq.* (1991).[5]

Entirely consistent with these rights is the right to control one's death when it is imminent – arguably the most fundamental right of all.

B. The Views of People with Disabilities

According to a major public opinion poll, 66 percent of people with disabilities support the right to assisted suicide, as compared with 70 percent of the general population. Louis Harris and Associates, Harris Poll no. 9, Table 105 (1995). This result is corroborated by a recent study which found that 63 percent of people with AIDS support this right, and 55 percent actually have considered this option for themselves. William

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[3] The Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq. (1990).

[4] *See generally*, Jane West, ed., THE AMERICANS WITH DISABILITIES ACT: FROM POLICY TO PRACTICE (1991); Jane West, ed., IMPLEMENTING THE AMERICANS WITH DISABILITIES ACT (1996); Mark Nagler, PERSPECTIVES ON DISABILITY (2nd ed. 1993); Lawrence O. Gostin & Henry A. Beyer, eds., IMPLEMENTING THE AMERICANS WITH DISABILITIES ACT: RIGHTS AND RESPONSIBILITIES OF ALL AMERICANS (1993).

[5] The Individuals with Disabilities Education Act (IDEA).

Breitbart, et al., *Interest in Physician-assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 Am. J. Psychiatry 238 (1996). Another study found that 90 percent of people with AIDS support the right. Brett Tindall et al., *Attitudes to Euthanasia and Assisted Suicide in a Group of Homosexual Men with Advanced HIV Disease*, 6 J. Acquir. Immune. Defic. Syndr. 1069 (1993).

While resolution of this issue by a poll of those most affected would quickly end criminalization of assisted suicide, constitutional issues are not rightly settled by popular vote. The personal and religious views of those who support either side of this national debate are immaterial to the question of whether patients who are terminally ill have a constitutional right to receive such assistance. However, the experiences and treatment realities of those who have lived with disabilities, including cancer and AIDS, are relevant to the Court's analysis. These experiences provide an explanation of why a decision, and request for assistance in accelerating death, is a legitimate treatment option which merits Fourteenth Amendment protection.

The experiences of those involved in the treatment of AIDS are particularly illustrative. Since the beginning of the AIDS epidemic in the early 1980s, people with AIDS and their advocates and service providers have been committed to ensuring that an individual with AIDS has as much autonomy in his or her life as possible. Many living with this disease have been involved decision makers in each stage of their treatment. In striving to maintain control over their lives as their physical conditions deteriorate, they have made increasing use of legal planning documents such as health care proxies and powers of attorney to maintain control of their final days. The right to end their lives with the assistance of their physicians is a natural extension of their efforts to maintain autonomy. The state's intrusion, effectively forcing a person to continue living against his or her will, destroys the autonomy that has been central to the struggles of people with disabilities.

Based on their experiences, it is clear that people with disabilities, like the public at large, believe that the state should

not be allowed to interfere with a terminally ill individual's personal decision of how and when to die. This important fact has been obscured by the vocal minority of those disability leaders who adamantly oppose recognition of the right to assisted suicide. Given the above statistics and the hard-fought battle for people with disabilities to win their autonomy, it is anomalous that some, purporting to represent the interests of people with disabilities, are advocating in favor of the state's right to interfere with the individual's autonomy.

In essence, those disability rights advocates opposing the right to assisted suicide appear to be saying that the individual with a disability should have control over every decision in his or her life, except for the decision of whether to live in the face of a terminal illness. This blatant contradiction is glaring and unacceptable to a substantial majority of people with disabilities.

C. The Interests of People with Disabilities

The interests of *Amici* are similar to the interests of millions of people with disabilities throughout this country. Although the personal circumstances of people with disabilities vary substantially, they share a common interest in maintaining control over their lives, including the ability to choose a dignified death.

The disabilities of some individuals, such as the individual *Amici*, will never be life-threatening or reach a terminal phase. To these individuals, issues concerning assisted suicide are the same as those for anyone else, except that some have a greater physical need for assistance. Like people without disabilities, these *Amici* want the right to make this choice for themselves if they someday become terminally ill. They do not want to be deprived of this right simply because they have disabilities. Nor do they want their disabilities to be used by others to justify a wholesale denial of this right.

Other individuals have disabilities which are more likely to become life-threatening, such as the individuals with AIDS represented by the two *Amici* organizations. For these *Amici*, the issue of whether there is a right to obtain physician assistance in

hastening death has a more immediate and direct impact. *Amici* in this situation want to be able to retain autonomy in making decisions about whether or when to end irreversible suffering if their illness or disability enters a terminal phase.

All *Amici* have a significant interest in how this issue is resolved. While not all are certain whether they would ever decide to hasten their own deaths, all want the freedom of knowing that this option will be available if the worst were to occur. Further, they want the security of knowing that they can exercise this option safely, effectively and legally with professional assistance. *Amici* believe that this would be a uniquely personal, moral and religious decision, one that would primarily impact themselves and their loved ones -- a decision that they should have the right to make for themselves without undue state interference.

In his personal statement, *Amicus* Evan A. Davis expresses concern that this Court may be misled by disability organizations claiming recognition of a right to die with the assistance of one's physician would harm people with disabilities. He points out:

> The narrow issue before this Court is whether a terminally ill person whose death is inevitable and imminent has a right to die with dignity. Thus this case concerns only circumstances where life is already ebbing out and the natural process of death has already begun. In these circumstances I do not want myself or any others to be deprived of an ability to die with dignity because of arguments about the interests of people with disabilities that are not accurate or germane.

Personal statement of Evan A. Davis.

II. SUMMARY OF ARGUMENT

Like others in our society, people with disabilities wish to define their concept of existence, and to have autonomy over the uniquely personal decisions that effect their lives. Unlike most

other people, many of their basic rights have been denied until very recently. After having fought for their rights for so long, and having achieved recognition through enactment of the ADA as citizens fully capable of autonomy, they are offended that, on the basis of their disabilities, others are attempting to deny them and all other Americans the right to end their lives with dignity if they become terminally ill.

People with terminal illnesses have a liberty interest under the Fourteenth Amendment to end their lives with the assistance of their physicians, if they so choose. This liberty interest must be considered fundamental. It is at least as strong as other liberty interests recognized by this court, such as the right to terminate life support. Specifically, the current cases involve the right of an individual who is acutely aware of his or her suffering and impending death, and whose decision to hasten death by a few days or weeks does not harm the interests of any other person or potential person.

Assuming that the right is fundamental, the blanket prohibition in this case denying the right to all terminally ill individuals is not a narrowly tailored restriction necessary to achieve a compelling state interest. In fact, there is no compelling state interest in denying a person who is suffering and has little life left from ending his or her life with dignity. Any interests that the state has in denying the right are significantly outweighed by the interests of the individual. All legitimate state interests, such as ensuring competence, preventing coercion, and avoiding abuse, may be achieved through state regulation that does not unduly interfere with the basic right.

All objections raised by members of the disability community who oppose recognition of the right are either misplaced or may be addressed through appropriate regulation. Contrary to their assertions, neither the liberty interest in hastening death with physician assistance nor the diminished state interest in preventing this from occurring is in any way based upon quality of life considerations being imposed on the individual. It is derived from the autonomy of terminally ill

individuals to determine whether they wish to continue to live with their suffering for the brief remainder of their lives.

Moreover, any objections based on the Equal Protection Clause and the ADA lack merit. Terminally ill individuals are not similarly situated to people who are not terminally ill. They are dying, soon and often in great pain, and the right to end their suffering and control their deaths is a significant benefit to them. Giving them that respect does not deny them the protection of the state and does not discriminate against them in any way.

In contrast, as the Second Circuit found, competent, terminally ill individuals are similarly situated to people on life support who, when competent, indicated that they did not wish to live under those circumstances. Denying terminally ill individuals the right to assisted suicide violates the Equal Protection Clause.

In a compassionate society that respects the autonomy of people with disabilities, we must not deny people with terminal illnesses the right to end their suffering. For these individuals, physician assistance is the only means by which to ensure that their lives will end in a safe and humane manner.

III. ARGUMENT

A. PEOPLE WITH DISABILITIES ASSERT THAT PEOPLE WITH TERMINAL ILLNESSES HAVE A CONSTITUTIONAL RIGHT TO HASTEN INEVITABLE DEATH WITH THE ASSISTANCE OF THEIR PHYSICIANS

1. Competent, Terminally Ill Adults Have a Strong Liberty Interest Under the Fourteenth Amendment in Making End-of-Life Decisions Free of Undue Government Interference[6]

Because of the long struggle for recognition of their autonomy, the Fourteenth Amendment's Due Process limitations on the state's ability to intrude into the most important and personal matters of our lives has particular importance to people with disabilities. *Amici* agree with the Ninth Circuit that there is a liberty interest in determining the time and manner of one's death, and that "[c]ertainly, few decisions are more personal, intimate or important than the decision to end one's life, especially when the reason for doing so is to avoid excessive and protracted pain." *Compassion in Dying v. State of Washington*, 79 F.3d 790, 813 (9th Cir. 1996).

Amici further agree with the Ninth Circuit's application of *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (*aff'g Roe v. Wade*, 410 U.S. 113 (1973)) and *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261 (1990)). The right to "define one's own concept of existence," found in *Casey*, 505 U.S. at 851, and to

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[6] Although the Ninth Circuit decided this case on the basis of a Fourteenth Amendment liberty right, and this brief will focus on that right, Amici believe that there are additional bases for finding a right to assisted suicide. In particular, they contend that there is a strong privacy right in the Constitution for people with terminal illnesses to be protected from state intrusion. As Justice Brandeis stated in his famous dissent in *Olmstead v. United States*, 277 U.S. 438, 478 (1928), the framers of the Constitution "conferred, as against the government, the right to be left alone--the most comprehensive of rights, and the right most valued by Civilized men." In addition, at least one commentator has argued that a Fourteenth Amendment property right in one's body precludes state prohibition of assisted suicide. Roger F. Friedman, *It's My Body and I'll Die if I Want To: A Property-Based Argument in Support of Assisted Suicide*, 12 J. Contemp. Health L. & Pol'y 183 (1995).

have autonomy over the "uniquely personal decisions" that affect their lives, found in *Cruzan*, 497 U.S. at 281, are extremely important to people with disabilities. Where for generations, almost every aspect of their existence was defined by a paternalistic society that labeled them inferior and relegated them to institutions, they are unwilling to relinquish their autonomy.

This Court has previously found that a liberty interest is implicated when an individual is subject to state-imposed pain and suffering, even when such pain and suffering involves no more than a student being paddled for disciplinary purposes. *Ingraham v. Wright*, 430 U.S. 651, 674 (1977). In the current cases, the states are effectively forcing terminally ill individuals to incur severe pain and suffering. The state's interest in preventing the individual from escaping this anguish is minuscule.

The liberty interest asserted here is also no less compelling than that in *Cruzan*, where this Court recognized a competent individual's liberty right to refuse medical treatment and obtain active medical assistance in withdrawing existing treatment even when this will result in death. *Cruzan*, 497 U.S. at 261. Here, Respondents and *Amici* seek recognition of a right for terminally ill individuals to obtain medical assistance that will likewise cause death. While Nancy Cruzan could have lived for years unconscious on life support, the individuals in this case were fully conscious of their brief remaining life, their pain and suffering, and their desire to end their suffering.

2. The Second Circuit Implicitly Agreed With the Ninth Circuit That There is a Liberty Interest for People with Disabilities (and Other Individuals) With Terminal Illnesses in Hastening Their Own Death

Although the Second Circuit decided *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996), based on the Equal Protection Clause of the Fourteenth Amendment, it is clear from its language that there is a due process liberty interest in deciding when and how to die. *Quill*, 80 F.3d at 725. In discussing "the protection of minorities,

the poor, and the non-mentally handicapped," the court concluded that "[i]n point of fact, these persons themselves are entitled to hasten death by requesting [withdrawal of life support] **and should be free to do so by requesting appropriate medication to terminate life during the final stages of terminal illness.** *Quill*, 80 F.3d at 730 (emphasis added).

As one commentator concluded, "[t]he Second Circuit ...says that no such liberty interest exists, yet in effect bases its Equal Protection Clause analysis on the existence of just such an interest." Christopher N. Manning, *Live and Let Die? Physician-Assisted Suicide and the Right to Die*, 9 Harv. J.L. Tech 513, 515 (1996). Thus, while certiorari was granted in this case in part due to differences in the reasoning of the two Circuit courts, there seems to be greater agreement between the Circuits that there is a liberty right to assisted suicide than is apparent from the Second Circuit's holding.

3. The Liberty Interest Asserted Here Is Fundamental and May Not Be Impaired Without a Compelling State Interest

These cases are about the ability of a terminally ill individual to die with dignity; however, they are equally about whether we, as a society, believe that the state should be allowed to impose itself at the patient's deathbed, between the patient, family members and the physician, as an equal medical decision maker. They are about whether terminally ill individuals are accorded the respect they deserve in making what may be the most difficult decision of their lives, and whether the state may incarcerate their physicians for honoring their request.

Amici believe that the ability of the state to intrude in and interfere with the final wishes of a dying person is unacceptable in a free society. They contend that the decision of terminally ill individuals to select the time and manner of their deaths cannot be infringed upon by a state without a compelling state interest that is achieved through a narrowly-tailored restriction. *Reno v. Flores*, 507 U.S. 292, 301-02 (1993). *Amici* agree with Justice Stevens, who in his dissent in *Cruzan*, concluded "[c]hoices about

death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly "so rooted in the traditions and conscience of our people as to be ranked as fundamental..."[7] *Cruzan*, 497 U.S. at 343 (emphasis added).

4. There is No Compelling State Interest in Denying Terminally Ill Individuals the Right to Die, and the Liberty Interest of the Individual Substantially Outweighs Any State Interests

If this Court finds the interest being asserted here is fundamental, as *Amici* contend, any restriction on pursuing that interest must be narrowly tailored to further a compelling state interest. *Reno*, 507 U.S. at 301-02. The restrictions being considered are not narrowly tailored; they fully preclude individuals from obtaining the assistance of their physicians in hastening their death. Moreover, there is no compelling state interest that would justify the denial of the final wish of a suffering terminally ill individual to end his or her life with dignity.

If, on the other hand, this Court finds the interest asserted is only important, it must be balanced against other relevant state interests. *Cruzan*, 497 U.S. at 279; *Youngberg*, 457 U.S. at 321. After an exhaustive analysis of all relevant state interests, the Ninth Circuit found that the balance weighs heavily in favor of the individual. *Compassion in Dying*, 79 F.3d at 799. *Amici* agree with this analysis, and wish to add only that the interests of the state in protecting competent people with terminal illnesses (or people with other disabilities) is no greater than its interest in protecting other competent individuals.

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[7] Justice Stevens further found that "... not much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience." *Id.* *Amici* strongly agree. *See* Statement of Amicus Evan Davis.

Amici recognize the legitimate interest of the state in protecting and preserving life. The interest in protecting life is best furthered by ensuring that the decision to end life with the assistance of a physician, is made voluntarily, by a competent, terminally ill individual. The state always has this interest and may pursue it through effective regulation.

However, the state's interest in *preserving* life diminishes, and the interest of the individual to be protected from state intrusion increases, as the potential for life diminishes. *In Re Quinlan*, 355 A.2d 647 (N.J. 1976), *cert. denied sub nom* 429 U.S. 922 (1976). *Garger v. New Jersey*, 429 U.S. 922 (1976). The interest of the terminally ill individual in ending his or her suffering far exceeds that of the state in preserving what little life remains.

While *Amici* recognize the legitimate interests of the state in protecting individuals from the actions of others, they and the majority of people with disabilities in this country do not want the protection of the state from their own actions and decisions.

5. The Legitimate State Interest in Protecting People with Terminal Illnesses or Other Disabilities from Abuses Can Be Protected Through State Regulation

The state has a legitimate interest in ensuring that all individuals who seek physician assisted suicide are competent adults who have made their decision voluntarily, without coercion or undue influence. In addition, the state may legitimately seek to ensure that the individual has had access to medical or psychological counseling and is fully aware of his or her options. *See* personal statement of *Amicus* Barbara Swartz.

A state may enact rules to protect state interests so long as they do not impose an undue burden "with the purpose or effect of placing a substantial obstacle in the path of" the ability to make the constitutionally protected decision. *Casey*, 505 U.S. at 877. In the context of physician assisted suicide, the state may not regulate with the purpose or effect of placing a substantial

obstacle in the path of a terminally ill individual to end his or her life with the assistance of a physician.

There are, however, clear measures a state might take to protect its legitimate interests. In particular, as long as it does not cross over the substantial-obstacle line, a state might impose the following safeguards:

- requiring the individual to repeat the request on more than one occasion;
- requiring the request to be made to more than one doctor;
- requiring the individual to be provided an opportunity to discuss the decision with a mental health professional;
- requiring the individual to be informed of programs and resources that are available to improve the quality of his or her remaining life; and
- requiring the individual to be informed on several occasions that he or she may, and is encouraged to, change his/her mind at any time.

These illustrate several of the requirements a state would be allowed to impose to protect its legitimate interest in ensuring competent, voluntary decisions and preventing coercion to choose hastened death. In addition, states may require hospitals, nursing homes, and other medical institutions to report on their compliance with these requirements.

Amici are committed to ensuring that the right of terminally ill individuals to obtain physician assistance in dying with dignity is not abused, that all individuals who choose to hasten their deaths do so freely, without pressure or coercion, and that they are aware of available options should they choose to continue to live. *See* personal statement of *Amicus* Susan Webb.

B. THE RIGHT TO ASSISTANCE IN DYING WILL BENEFIT PEOPLE WITH TERMINAL ILLNESSES, AND WILL NOT ADVERSELY AFFECT OTHER PEOPLE WITH DISABILITIES

1. Neither the Strong Liberty Interest in Hastening Death, Nor the Diminished State Interest in Interfering With This Decision, Are Based on Any Externally-Imposed Quality-of-Life Considerations

Some disability organizations that oppose the right to assisted suicide contend that the right is based on a social perception that people with terminal illnesses and other disabilities have a diminished quality of life. This contention is inaccurate. The strong liberty interest of terminally ill individuals in controlling the circumstances of their deaths, and the diminished state interest in interfering with this decision, are derived from their autonomy in making decisions about what little remains of their lives.

The interests do not derive in any way from any perceived diminished quality of life for individuals with disabilities or terminal illnesses. Quality of life is a subjective valuation belonging to the individual, not the courts or the states. Whether the quality of the life remaining for a terminally ill person is sufficient to justify whatever pain and suffering he or she may be enduring is a decision for that person, and that person alone.

2. The Right to Hasten Inevitable Death is a Benefit for People with Terminal illnesses That is Not Prohibited By Either the Equal Protection Clause or the Americans with Disabilities Act.

Some opponents of the right argue that it would deprive people with disabilities of the equal protection of the laws and would otherwise discriminate against them in violation of the ADA. These arguments are based on a fundamental

misunderstanding of the right. They characterize the benefit to terminally ill individuals of a right to hasten their own death as the discriminatory denial of a statutory right to be protected from their own decisions to end their lives. Regardless of this flip-flopped reasoning, the majority of people with disabilities regard the right to death with dignity as a benefit, not a legal detriment.

The Equal Protection Clause of the Fourteenth Amendment commands that no state shall "deny to any person within its jurisdiction the equal protection of the laws," which essentially means that all persons who are similarly situated should be treated alike.[8] *City of Cleburne, Tex. v. Cleburne Living Center*, 473 U.S. 432, 439 (1985). The threshold question is whether people with terminal illnesses are similarly situated to non-terminal individuals with respect to their interest in dying. The answer is clearly no. Terminally ill individuals who are at the end of their lives, often with severe pain and suffering, have a different interest in end-of-life decisions than others.

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[8] It is currently not clear what standard of review should apply to legislative classifications based on disability for purposes of equal protection analysis. On the one hand, the Supreme Court clearly found that people with mental retardation (perhaps the most vulnerable group in the disability community) are not entitled to heightened scrutiny. *Cleburne*, 473 U.S. at 422. On the other hand, *Cleburne* was decided in 1985, prior to the Congressional finding in the enactment of the ADA that "individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society based on characteristics that are beyond the control of such individuals . . .." 42 U.S.C. § 12101(a)(7). Based on this finding, this Court may find that legislative classifications based on disability must receive the highest level of scrutiny. *Cf. Trautz v. Weisman*, 819 F. Supp. 282 (S.D.N.Y. 1993). Whichever standard this Court decides to apply, the right of terminally ill individuals to end their lives does not violate the Equal Protection Clause for reasons discussed herein.

Moreover, given the nature of the right at issue here, it is more appropriately viewed as an interest held by all individuals that may be exercised as a right if and when they become terminally ill, rather than a right held by terminally ill individuals and not others. Terminal illness, like disability generally, does not discriminate; it may affect anyone. Denying people who are not terminally ill the right to end their lives with physician assistance, until such time that they become terminally ill, does not deny them equal protection.

The second question is whether the right to assisted suicide deprives people with terminal illnesses of a benefit that is available to other individuals. Again, the answer is no. The right being asserted here would give terminally ill individuals an additional choice that they currently do not have. It would not require them in any way to exercise that choice. It would not deprive them of life. It would not deprive them of protection from murder. It would not deprive them of state suicide prevention services. In fact, it would not deprive them of anything.

The ADA prohibits actions by or policies of public entities that "exclude from participation in" or "deny the benefits of" any program, service, or activity of a public entity or by which persons are "subjected to discrimination by any such entity." 42 U.S.C. § 12132. Again, the right being asserted does not deny any benefit to any person with a disability, nor does it exclude any person with a disability from participation in any state program, service or activity.[9] The ADA was not intended to

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[9] The one way in which the ADA may be applicable, however, is with respect to individuals with terminal illnesses who are not capable of self-administration of the lethal drug. Certain people with disabilities, such as some people with quadriplegia, have physical limitations which severely restrict or render impossible the ability to self-administer drugs. Modern technology has resolved this issue for the vast majority of these individuals through the development of assistive devices that allow them to self-administer. However, to the extent that

(continued...)

prevent people with disabilities from having greater options than other people, particularly when they are entirely free not to exercise those options.

Moreover, the ADA was not intended to protect people with disabilities from their own decisions. One form of discrimination against people with disabilities explicitly mentioned as a basis for the ADA is "overprotective rules and policies." 42 U.S.C. § 12101(5). Terminally ill individuals have a particularly strong liberty interest in not being "protected" by the state from their own end of life decisions. The right to obtain physician assistance to hasten their death is a significant benefit to them. They do not want protection from this choice.

3. The Standard of Terminal Illness Will Allow States to Prevent People Who Are Not Terminally Ill from Ending Their Lives With Physician Assistance

Some disability organizations that oppose assisted suicide contend that this right inevitably will be expanded to people with disabilities who do not have terminal illnesses. There is no reason this will occur. The requirement that the individual seeking to end his or her life must have a terminal illness that makes death imminent and inevitable is readily capable of definition and implementation. Many states and model codes define the term "terminal illness." Brief of Respondents *(Glucksberg)* at 32.

The fact that there is no uniform definition for "terminal illness" is of little consequence. At this stage, we need only consider the broad parameters of the right. In the current cases,

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9(...continued)
some of these individuals who are terminally ill are incapable of self-administration even with an assistive device, the ADA would probably require that the individual be permitted the assistance of his or her physician in administering the drug. Such administration would be entirely consistent with the active role that physicians currently play in conducting abortions and in terminating life support systems.

all people with terminal illnesses are precluded from obtaining the assistance of their physicians in ending their lives. This blanket prohibition clearly violates the liberty rights of many individuals who are, without any doubt, terminally ill. As long as a state defines terminal illness within the bounds of reasonableness, it may prevent people who fall outside those bounds from obtaining assistance in dying.

Some opponents point to the Netherlands as proof that the right to physician assisted suicide cannot be contained to people with terminal illnesses. Any such comparison is misleading. In the Netherlands, physician-assisted suicide is not allowed by statute, but physicians who adhere to official guidelines will not be prosecuted for assisting patients who request assistance in dying. However, those guidelines have never required that the patient be terminally ill or that the patient's suffering be physical. Chris Docker, *Euthanasia in Holland*, ¶ 1 (1996) <http://www.euthanasia.org/ dutch.html>.

Two recent studies of doctor-assisted death in the Netherlands suggested that tolerance of the practice has not produced the "slippery slope" leading to abuses which critics have predicted. P.J. van der Mass, et al., *Euthanasia, Physician-Assisted Suicide and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 N. Eng. J. Med. 1699 (Nov. 28, 1996); G. Van Der Wal et al., *Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands*, 335 N. Eng. J. Med. 1706 (Nov. 28, 1996); M. Angel, *Euthanasia in the Netherlands – Good News? Or Bad?*, 335 N. Eng. J. Med. 1676 (Nov. 28, 1996).

The situation in the Netherlands, therefore, provides no support for the proposition that the right limited to terminally ill individuals in our country will necessarily be expanded.

4. The Standard of Voluntariness Will Allow States to Ensure Only Competent Individuals Who Choose to Hasten Death With Assistance Are Allowed to Do So

Opponents of the right to die further assert that people with disabilities will be induced to end their lives by others who consider them inferior or a burden. However, the right asserted here is based entirely on the voluntary choice of a competent individual with a terminal illness to end his or her life. As discussed above, the state is free to enact regulations to ensure that the decision is made voluntarily by a competent adult who was not subject to coercion or undue influence. Despite such standards, opponents contend that this right will be extended to incompetent individuals. They base this conclusion on case law concerning the right to refuse life-sustaining medical interventions. However, such expansion is by no means inevitable and may be precluded by this Court's decision.

The liberty right to assisted suicide is different from the right to withdraw life support. While competent individuals in both situations are similarly situated for purposes of equal protection analysis, the right to withdraw life support is based fundamentally on the common law right to be free from bodily invasions. *Cruzan*, U.S. at 269. The courts have appropriately found that, like competent individuals on life support, incompetent individuals have a right to be free from such invasions. The right to assistance in dying is based on the interest of the terminally ill individual to control his or her life. Because the right is based on the autonomy of the individual, it may be limited to those individuals who are capable of autonomy–competent adults.

5. In the United States, the Right of Terminally Ill Individuals to Choose Assisted Suicide Will Never Be Converted into a Right of the State to Authorize the Murder of People with Disabilities

Some organizations that oppose physician assisted suicide for competent patients who are dying and suffering contend that this is the first step toward a society in which life is devalued and people with disabilities are routinely killed by their doctors. These groups point to the "euthanasia" program authorized by

Nazi Germany in the 1930s as a graphic example. There are several serious problems with this analogy.

First, our country is not Nazi Germany; ours is a nation dedicated to individual freedom in which the state is constitutionally limited in depriving individuals of life, liberty or property and the press is constitutionally empowered to inform the citizenry of abuses of state power. The notion that the state will have an interest in killing, or authorizing the killing of, people with disabilities is ludicrous. One could just imagine the TV coverage of such abuses on the evening news, or "60 Minutes", as well as the criminal and civil legal actions that would inevitably follow.

Second, the Nazi program did not begin by granting a right to assisted suicide for people with terminal illnesses. It began with a determination by the state that people with disabilities are inferior, have an inferior quality of life, and are therefore disposable. That determination was in fact entirely consistent with the goals and ideals of the Nazi party, and flourished when the party flourished. By contrast, the notion that people with disabilities may be killed without their consent is, and will always be, abhorrent to the American public. The false notion that they are inferior or necessarily have an inferior quality of life may never in this country serve as a basis for any public policy, particularly a policy that would deprive them of life, liberty or property. The right being sought here is not in any way based on any perceived inferiority, or inferior quality of life of, people with terminal illnesses.

Third, and most important, the state in Nazi Germany gave the medical profession unbridled power and authority to control the lives and deaths of individuals with disabilities. In current cases, Respondents and *Amici* seek to expand individual autonomy and liberty, and to diminish the power and authority of the state to make or authorize decisions concerning the life and death of an individual. The implication of recognition of a right to assisted suicide is, therefore, not that the state will have more

power to take the life of any of its citizens, with or without disabilities, but rather that it will have less power.

Amicus Hugh Gallagher, author of *By Trust Betrayed: Patients, Physicians and the License to Kill in the Third Reich*, and one of the world's foremost experts on the Nazi euthanasia program, describes in his personal statement how the medical establishment in Germany, at its request, was authorized by the government to provide a "mercy" death for patients who in the judgment of their physicians had "lives not worth living," and that the patients were given no choice over whether to live or die. In indicating his support of the right to assisted suicide, he concludes that:

> The Nazi's euthanasia program offers a horrible example of how easy it is to go wrong when the state or a group authorized by the state is allowed to assume the power to judge the worth of another. Ironically, this program is now being used by some as a justification to deny Americans in the terminal stage of illness the right to die with assistance. In fact, the German experience shows how important it is that the autonomy of people with disabilities be honored in all aspects of their lives. . . .
>
> The case of assisted suicide is quite different: the patient with a terminal illness retains complete choice over whether to live or to die. Neither the state nor the physician may decide, based on their conceptions of the individual's quality of life; the individual must assess his or her own quality of life. This is true whether or not the individual has a disability....
>
> To my mind, the issue comes down to control -- control over one's Self. This control over Self is the very heart of the disability rights struggle. In Nazi Germany 60 years ago, people with disabilities were deprived of all control over their Selves. They were killed not because they sought death but because they did not measure up to "quality of life" standards set

> by their physicians with the concurrence of the state. This must never happen here.

Personal statement of Hugh Gregory Gallagher.

C. DENIAL OF THE RIGHT TO ASSISTANCE IN DYING WOULD DENY PEOPLE WITH TERMINAL ILLNESSES THE EQUAL PROTECTION OF THE LAWS

While the people with terminal illnesses in these cases are not similarly situated to people who are not terminally ill for purposes of the Equal Protection Clause, they are similarly situated to competent people on life support who have clearly indicated that they do not wish to live under such circumstances. *Amici* agree with the decision of the Second Circuit that "New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs." *Quill*, 80 F.3d at 729. *See*, personal statement of *Amicus* Barbara Swartz.

D. A COMPASSIONATE SOCIETY THAT RESPECTS PEOPLE WITH DISABILITIES MUST NOT DENY TERMINALLY ILL INDIVIDUALS THE RIGHT TO END THEIR SUFFERING WITH ASSISTANCE

People with terminal illnesses have an immediate and urgent liberty interest in the right to hasten their death with the assistance of their physicians, whether or not they decide to exercise that right. Diseases such as cancer and AIDS may cause great pain and suffering, physical deterioration, and mental anguish. A society that cares about these individuals and that respects their autonomy must not deny them the opportunity to shorten the period of their suffering and to die with dignity in a safe and effective manner, with the assistance of their physicians.

1. The Decision of a Competent, Terminally Ill Individual to End His or Her Life Must Be Assumed to Be Rational and Should Be Respected

In our legal system, the decisions of competent individuals are presumed to be rational.[10] This presumption applies to the decisions of people with disabilities, and any contrary assumption by a state in establishing its policy would violate the ADA and our national policy concerning people with disabilities. Therefore, a state may not assume that the decision of a competent terminally ill individual to end his or her life is irrational and may not base a policy precluding assisted suicide on such an assumption.

Yet, some disability rights advocates who oppose the right to die seem to argue that people with disabilities are not capable of autonomy for purposes of determining when and how they should die when facing death with a terminal illness. The reason for this apparent inconsistency with their basic philosophy is that, they contend, many people with disabilities have so few resources or viable options that they cannot make a rational choice to end their lives. This inconsistency is unacceptable to *Amici* and the majority of people with disabilities.

Amici are leaders in the disability community who are committed to improving the lives of all people with disabilities and to enhancing the options available to them. They agree that our society often does not provide the support necessary for people with disabilities to live independently in their communities. However, the fact that the circumstances of the disabled population are, as a whole, far less than ideal in this country, and are likely never to be perfect, is no justification for depriving those who have a terminal illness of the right to end their suffering. These individuals are entirely capable of making rational decisions. *See* personal statement of Susan Webb.

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[10] *See, H.L. v. Matheson*, 450 U.S. 398, 453 (1951); *Davis v. United States*, 160 U.S. 469, 477 (1895).

As indicated above, between 66 and 90 percent of people with AIDS support the right to assisted suicide. Significantly, the study that found that more than half (55 percent) have considered this option for themselves, also found that the strongest predictor of interest in physician assisted suicide was having witnessed terminal illness in a family member or friend. Breitbart, *supra* at 242; Tindall, *supra* at 1069. This suggests that these individuals know from personal experience the pain and suffering a terminal illness can impose, and have concluded that a person should have the right to end that agony if they so choose. According to one observer:

> Patients who are dying of cancer and wish to lessen their suffering raise the concept of rational suicide. They are competent to make decisions, feel that they have completed their contribution to the world, and are unlikely to contribute anything more in the few weeks remaining. The disease is advanced and advancing, and they understand and accept it. Estimates of survival are in weeks rather than months, and they are quite willing to relinquish the possibility of another remission. They do not believe in miracles. Indeed, their condition may be so pitiful as to command the sympathy of family, friends and caregivers alike. The only desire is to shorten the process of dying and terminate the suffering.

Charles F. McKhann, *Is There a Role for Physician-Assisted Suicide in Cancer? Yes*, Important Advances in Oncology, 267, 269 (1996).

2. Recognition of the Right to Receive Physician Assistance Will Serve to Ensure Safety and Curtail Abuse

As was true with abortion in the years before this Court's decision in *Roe v. Wade*, the continued criminalization of physician assisted suicide has not stopped many physicians from aiding competent patients to end their suffering. *See* Jody B. Gabel, *Release From Terminal Suffering? The Impact of AIDS on*

Medically Assisted Suicide Legislation, 22 Fla. St. U.L. Rev. 369, 372-73 (1994); L. Slome, J. Moulton, C. Huffine et al., Physicians' attitudes toward assisted suicide in AIDS, 5 J. AIDS 712-18 (1992); Dick Lehr, *Death & the Doctor's Hand, Increasingly, Secretly, Physicians Are Helping the Incurably Ill to Die*, Boston Globe, Apr. 25, 1993 at 1.

In the face of legal prohibitions on physician assistance, others are coming to the aid of the dying. One recent study surveyed 1139 critical care nurses in the United States, of which 71 percent practiced exclusively in intensive care units for adults. Of that group, 17 percent reported requests from patients or family members for euthanasia or assistance in suicide;[11] 16 percent of those asked, did so. An additional 4 percent stated they had hastened a terminally ill patient's death by pretending to provide life-sustaining treatment ordered by a physician. David Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 N. Eng. J. Med. 1374-79 (May 23, 1996).

One California study of persons caring for loved ones with AIDS found more than 10 percent of these caregivers reported giving drugs to hasten their loved ones' death. M. Coode, L. Gourlay, L. Collette et al., *Dying of AIDS: The Role of Caregivers in Terminal Care and Hastened Death*, Center for AIDS Prevention Studies, University of California, San Francisco, Paper presented at the 10th International Conference on AIDS, Yokohama, Japan, August, 1994.

The ban on assisted suicide has simply ensured that persons lacking the requisite training will continue to intervene on behalf of those wishing to die. A desperate individual left to his or her own devices may likewise be forced to resort to whatever means are available to curtail suffering, such as "hanging, suffocation or shooting." Jeremy A. Sitcoff, *Death with Dignity: AIDS and a Call for Legislation Securing the Right to Assisted Suicide*, 29 J.

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[11] David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 N. Eng. J. Med. 1374-75 (1996).

Marshall L. Rev. 677, 687 (1996). Without physician assistance, the consequences may be other than intended, potentially resulting in severe injury (e.g., coma, brain damage or increased agony). "Often, the person who has made a rational choice to die with dignity must accept his death in a totally undignified manner". *Id.*

3. People with Terminal Illnesses Should Not Be Compelled to Die in a Drug-Induced Semi-Conscious Haze

The typical treatment of people with terminal illnesses that cause great pain is to administer high levels of pain medication to the individual, which typically puts him or her in a semi-conscious state for an extended period of time. In administering this medication, the physician is fully aware that there is a significant probability of killing the patient. However, this is considered sound medical practice, while assisting an individual with the intent to help the individual end his or her life is a criminal act.

Individuals should not be forced to spend their final days in a drug-induced stupor to alleviate their pain. To many individuals, the prospect of leaving this world in such a state of prolonged semi-consciousness is a fate worse than death. In one study of eighteen patients with cancer, one patient with prostate cancer and bone metastases stated: "Who wants to suffer this kind of pain? The medication puts me to sleep. As soon as I wake up, there is the pain. If I can't live free of pain, I'm not living at all, simply existing." McKhann, *supra* at 268.

With the option of physician assisted suicide, terminally ill individuals may choose to remain fully conscious, recognizing that they may end their suffering permanently at any time. This option, therefore, allows them to spend their remaining days saying good-bye to their friends and relatives and putting their affairs in order. To them, and to most people, this dignified exit is far preferable to having their loved ones look on hopelessly as they slowly drift from drug-induced semi-consciousness to death.

4. Physician Assisted Suicide Allows People with Terminal Illnesses to Postpone Ending Their Lives Until a Later Phase of Their Illness

The recognition by people with terminal illnesses that they can end their suffering often gives them the will to continue to live. A strategy of many terminally ill individuals is to determine the point in the disease process when it would be unbearable to live and to decide to end their lives at that point. The control that this gives them over their lives often allows them to sustain a willingness to live. Many times, individuals reach the planned point and extend their self-imposed limit to a later stage of the disease. Often, they postpone the decision permanently, and die from the disease. Mary Evangelisto, *Death with Dignity: End-of-Life Issues for the HIV/AIDS Patient*, 34 J. Psychosoc. Nurs. 45, 46 (1996).

IV. CONCLUSIONS

Issues of autonomy and self-determination are at the heart of the struggle of people living with disabilities. They want to be able to control the decisions that affect their lives. Like the majority of Americans, they particularly do not want the state to deprive them of such control during their final days, if they have decided their suffering is intolerable. This decision must be made by the individual in consultation with his or her loved ones and personal physician. The state has no legitimate place interfering in this profoundly personal decision making process.

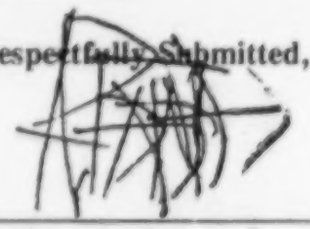
The right of terminally ill individuals to control their deaths is fundamental. There are few, if any, interests that are more basic to individual liberty, and few, if any, circumstances in which the state's interest is less. *Amici* do not want to be deprived of this right by the state simply because others, including others with disabilities, may not make this choice for themselves or because of concern over potential abuse. They do not want their disabilities to be used to justify the denial of this right to others. The interests of a dying person to control the remainder of his or her life far outweighs any state interests.

There is certainly no state interest sufficient to prohibit all people with terminal illnesses from obtaining compassionate assistance in dying from their physician.

Amici are committed to ensuring that the right to physician assisted suicide is applied fairly and appropriately. They believe that the vast majority of individuals who have available the option of physician assisted suicide will choose to live, comforted by the knowledge that the decision to continue to live is theirs and theirs alone. The enormous interest in this case by members of the disability community ensures that multitudes of disability rights advocates, including *Amici*, as well as other concerned individuals, will do everything they can to ensure this right is not abused and to encourage terminally ill individuals to choose to live.

The decision of the Ninth Circuit that people with terminal illnesses have a liberty right in ending their lives with the assistance of their physicians, and the decision of the Second Circuit that denial of this right constitutes a denial of the equal protection of the law, should be affirmed.

Respectfully Submitted,



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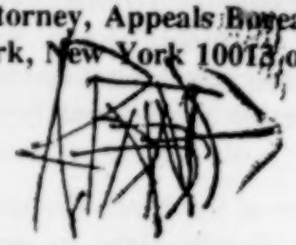
CERTIFICATE OF SERVICE

I HEREBY CERTIFY that true and correct copies of the foregoing were sent via U.S. mail to: William L. Williams, Deputy Senior Assistant Attorney General, Transportation and Public Construction Division, Office of the Attorney General, 905 Plum Street, Olympia, Washington 98504-0113; Barbara Billett, Solicitor General State of New York, Office of the Attorney General, The Capitol, Albany, New York 12224; and Marc F. Scholl, Assistant District Attorney, Appeals Bureau, One Hogan Place – Room 812, New York, New York 10013, on December 9, 1996.



Andrew I. Batavia

APPENDIX

PERSONAL STATEMENTS

OF

AMICI CURIAE

Personal Statement of Evan A. Davis

I am an attorney admitted to practice in the State of New York and a member of the Bar of this Court. I am a litigation partner with Cleary, Gottlieb, Steen and Hamilton in New York City. In 1949, at the age of five, I contracted polio and since then have gotten around with the help of braces, crutches and a wheelchair. For the last twenty years or so I have used the wheelchair almost exclusively. Because I received an excellent education and because my credentials are strong, this disability has not limited my practice.

I was asked to participate in this amicus brief by Professor Sylvia Law of New York University Law School. She told me that various groups representing persons with disabilities were filing amicus briefs in support of Petitioners urging that the interests of disabled people would be disserved by affirmance of the decisions below. As it happened I had just spent a good deal of time studying the legal issues now before this Court. With my knowledge of these issues in mind I agreed to participate because I thought the Court needed to be informed that if the issue before it is viewed narrowly, as it should be, affirmance would work absolutely no harm to the interests of people with disabilities.

My interest in this Court not being misled is two fold. The narrow issue before this Court is whether a terminally ill person whose death is inevitable and imminent has a right to die with dignity. Thus this case concerns only circumstances where life is already ebbing out and the natural process of death has already begun. In these circumstances I do not want myself or any others to be deprived of an ability to die with dignity because of arguments about the interests of people with disabilities that are not accurate or germane.

I also have an interest in this Court not being mislead because I believe it is uniquely the obligation of this Court under the Fourteenth Amendment to decide what is the proper scope of the citizen's right to be left alone by government in regard to seeking a dignified death. If this issue is left to the legislative process the result will likely be influenced by religious views whose sincerity I respect but which are contrary to my sincerely held religious views. Therefore I have a particularly strong interest in this Court making a sound decision on solely secular grounds based on accurate information.

Evan A. Davis

12/2/96

Date

Personal Statement of Hugh Gregory Gallagher

I am a writer and a historian. I am also a polio quadriplegic as a result of an attack of polio in 1952. For more than a decade, I have been studying and writing extensively on disability rights issues. I am particularly interested in the treatment that people with disabilities receive from the medical system. I am considered one of the foremost experts on the program authorized by Nazi Germany to "euthanize" over 200,000 of its citizens with disabilities.

The Nazi's euthanasia program offers a horrible example of how easy it is to go wrong when the state or a group authorized by the state is allowed to assume the power to judge the worth of another. Ironically, this program is now being used by some as a justification to deny Americans in the terminal stage of illness the right to die with assistance. In fact, the German experience shows how important it is that the autonomy of people with disabilities be honored in all aspects of their lives. I do not believe that people with terminal illnesses should be denied the option of ending their lives in order to obtain relief from intolerable pain and suffering. This most personal of all decisions should rest between the person and his God.

In my book, <u>By Trust Betrayed: Patients, Physicians and the License to Kill in the Third Reich</u>, I describe in detail how the medical establishment in Germany, at its request, was authorized by the government to provide a "mercy" death for patients who in the judgment of their physicians had "lives not worth living." The program was authorized by Hitler in 1939 and placed under the direction of his personal physician. Although the program was called "euthanasia," the vast majority of the people killed were not terminally ill or in great pain or even requesting death. The killings began slowly, but soon enough, entire wards were being provided "final medical treatment." The patients were given no choice over whether to live or die.

The case of assisted suicide is quite different: the patient with a terminal illness retains complete choice over whether to live or to die. Neither the state nor the physician may decide, based on their conceptions of the individual's quality of life; the individual must assess his or her own quality of life. This is true whether or not the individual has a disability.

In our generation, great strides have been made to welcome people with disabilities into society as equal members with equal rights. For the first time, people with disabilities have assumed control over their own lives, without fear of sterilization, internment, segregation and ostracism, and the denial to their rights to vote, hold property, enter legal contracts, and obtain public education, transportation and accommodation. Now they should no more be denied the right to obtain assistance in dying if they become terminally ill than should anyone else.

To my mind, the issue comes down to control -- control over one's Self. This control over Self is the very heart of the disability rights struggle. In Nazi Germany 60 years ago, people with disabilities were deprived of all control over their Selves. They were killed not because they sought death but because they did not measure up to "quality of life" standards set by their physicians with the concurrence of the state. This must never happen here.

In the United States today, we are debating whether an individual in the terminal stages of an illness should retain control over his/her Self and his/her personal concept of quality of life -- even to the point of death with dignity -- or whether such control should be circumscribed by the state.

In my own experience, it was this sense of control and the concomitant knowledge that I could end my life should the situation become unbearable, that kept me going through the extraordinary pain and suffering that accompanies acute polio. I will not turn over this control, or my personal decision to live or die, to the state. That decision is mine and mine alone.

Hugh Gregory Gallagher

Nov 28 1996

Date

Personal Statement of Barbara Swartz, Esq., In Support of Physician-Assisted Suicide

I have end-stage renal disease (ESRD) and have been considered legally disabled for the past twelve years. For eleven and a half years, I was a home hemo dialysis patient; six months ago, I had a successful kidney transplant. But I am more than a kidney patient. Professionally, I am a lawyer, a law professor and a lecturer in public health. During these past twelve years, I have been very active as a volunteer in my national kidney organization.

Throughout my career, I have been a fighter for and protector of human rights. I have worked for prisoners' rights, women's rights and patients' rights. A common theme running through these various areas is my strong commitment to the right of the individual to maintain her autonomy and dignity. In the area of patients' rights, I believe in the full and active participation of patients in our own health care decisions including end of life and death decisions. It is in making these profoundly difficult decisions that the right to individual autonomy becomes most meaningful. Competent patients already have the legal right to refuse treatment even if this decision leads to their death. In my mind, there is little legal difference between this right for a physician to help a person die with dignity, and the opportunity for a physician to prescribe medication which a competent person may choose to self-administer even though it too may lead to her death. In both cases, we are discussing the means used, either passive or proactive, to achieve the same end result. As a competent patient, I believe passionately in my right to maximum participation in one of the most intimate decisions that affects me: how I die.

I do not say that this is an uncomplicated issue and I understand that honorable people may disagree on what approach to take in cases of people wishing to die when they are in the end stages of a terminal illness. Before a physician consents to a patient's request for a lethal dose of medication, I would want to ensure that a patient is offered effective pain management and appropriate psychological assistance. Ideally, I would also like to believe that there has been an active and ongoing dialogue between the physician and the patient about this decision. But this is a matter of effective regulation rather than a strict prohibition of the practice. Ultimately, I believe that the final decision about whether to live or die must be left to the patient.

I have always been actively involved in decision making about my illness. From the onset of my kidney disease, I had to make the decision about whether to go on dialysis or not. I knew that a decision not to choose dialysis was a

decision to die. Every time I dialyzed, I made the decision to choose life over death. I also had to decide whether to put myself on the transplant list and then when a kidney was offered to me, whether to accept the offer. Each of these decisions is more comparable to a competent person's right to refuse treatment. However, I would hope that if I chose to end my life because of unbearable pain and suffering, and I needed help, I would be able to call upon my physician to assist me in dying with dignity. For me, the basic question is whose life and death is it anyway?

Barbara Swartz, Esq.

Barbara Swartz, Esq.

November 30, 1996

STATEMENT OF MICHAEL A. STEIN

I am a thirty-three year old individual who uses a wheelchair due to a childhood illness that brought about spastic paraparesis. Aside from this limitation on my mobility, I am otherwise in good physical condition and enjoy an active and healthy lifestyle.

Professionally, I teach a course on Physical Disability Law at New York University Law School while working towards completion of my Ph.D. studies in legal history at Cambridge University. Thereafter, I will return to full time law teaching and advocacy for the rights of individuals with disabilities.

In the past, I have tried to advance the status of disabled people through the publication of law review articles (See, e.g., Mommy Has a Blue Wheelchair: Recognizing the Parental Rights of People With Disabilities, 60 Brooklyn L. Rev. 1069 (1994); From Crippled to Disabled: The Legal Empowerment of Americans With Disabilities, 43 Emory L.J. 247 (1994)), editorials (See, e.g., Attitudinal Barriers to Hiring Attorneys with Disabilities, 17 Physical and Mental Disability L. Rev. 214 (1993); When Justice is Blind: Appointing Vision-Impaired Individuals to the Bench, 1 Minority L.J. 5 (1992)), service as President of the National Disabled Bar Association (1992-94), and direct lobbying of members of the United States Congress.

On a personal note, I am newly wed to a wonderful person who makes me enormously happy. In other words, I have every reason to be grateful for my existence and to want its indefinite continuation.

Nevertheless, I feel so strongly about allowing people with disabilities the option of assisted suicide, that I readily agreed to be named as party in this amicus brief. This is because, whether through illness or other circumstances, occasions arise that make some peoples' lives unbearably painful. Without the option of a facilitated passing, their existence becomes no more than an extended personal torture as they are sentenced to wait for a grim and demeaning demise. By honoring an opportunity of assistance, those people who so choose, may regain control of both their existence and their dignity.

I believe that whether an individual chooses to bring about her own demise is an intimately personal choice and should remain a private decision, protected from state regulation. The blanket prohibition against assistance in the statute at bar is invasive, eradicating a difficult decision which must be made by an individual in consultation with his conscience, family and friends.

The option of assisted suicide should be available for people who currently desire this course as well as for others, such as myself, who want a similar freedom to act in case of future circumstances.

10/29/96

Michael A. Stein

Personal Statement of Susan Webb

This statement declares my personal support of a terminally ill individual's right to die. I also support a terminally ill individual's right to die with assistance of another when it is assured that the individual has made his/her decision in writing and has made the decision after as many options for living as practicable have been made available to him/her. Under no circumstances must an individual be assisted in his/her suicide under coercion, especially by the individual who will be assisting.

Like many other persons with a disability, I have some concerns about this issue. Many persons with disabilities are relegated to institutions such as nursing homes where they feel trapped and without other options based on archaic, paternalistic systems. The only information they are given is often from persons who are not themselves disabled and who cannot fully understand the disability experience firsthand and that life with a disability can be full and rewarding.

As a disability advocate I am personally committed to working on legislation, regulations, etc. that would guarantee that individuals with disabilities have access to resources and information that might lead them to choose life instead of death. I am committed to ensuring that no one chooses death because he or she does not have adequate information with which to make an informed choice. However, once a terminally ill individual has allowed considerable time and thought, with a complete understanding of their options, the decision to end his/her life with or without assistance must be respected and implemented.

I am a person who has lived with a significant disability since 1974. As a disability advocate, executive director of an independent living center, elected board member of a national disability-rights organization and compassionate American, I make this statement from a recognized position of expertise and after much forethought. However, this statement is to be construed as a personal declaration and in no way reflects the opinions of any organization to which I belong.

Susan Webb

12-3-96

Date